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2nd edition

Nolo's Guide to Social Security Disability

Getting & Keeping Your Benefits



All the plain-English information you need to:

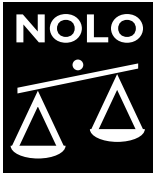
- apply for benefits
- keep existing benefits
- work while receiving payments
- understand Social Security Disability Insurance & Supplemental Security Income



by David A. Morton III, M.D.

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2nd edition

Nolo's Guide to Social Security Disability

Getting & Keeping Your Benefits

by David A. Morton III, M.D.



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Dedication

To my mother, Mary E. Morton, and to my wife, Mary L. Morton.

Acknowledgments

I would like to thank Nolo founder Ralph “Jake” Warner for seeing the need for a book on Social Security disability that can be read and used by ordinary people. I would also like to thank former Nolo editors Robin Leonard and Steve Elias for helping to take difficult and complex areas of law and medicine and make them accessible to the general public. Finally, my thanks to Nolo editors Spencer Sherman and Ilona Bray for finishing what Robin and Steve began.

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Introduction

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A. Introduction

This book is about Social Security disability benefits, which are provided through a U.S. government system run by the Social Security Administration (SSA). These disability programs provide cash support for individuals with mental or physical disorders (and their dependents) who cannot work because of the severity of their condition. This book is useful for anyone who:

- is injured or ill and wants to know if they are eligible for disability benefits
- wants to apply for disability benefits
- is already receiving disability benefits and wants to know how to protect them during periodic government reviews of their condition
- wants to appeal a decision denying them disability benefits, or
- is helping an adult or child apply for or keep current benefits.

The SSA uses two systems to distribute disability payments:

- Social Security Disability Insurance (SSDI), for workers who have paid into the Social Security trust fund (and their dependents), and
- Supplemental Security Income (SSI) for disabled individuals with limited incomes and assets (and their dependents).

It is easy to become overwhelmed at the thought of applying for disability. The Social Security Administration is one of the world's largest bureaucracies; its regulations, rules and operating policies and guidelines fill reams of paper. One chapter of the SSA operating manual dealing with disability issues for people who contributed Social Security taxes is about 10,000 pages long. And much of this information changes over time.

Still, it is very possible to apply for, receive and maintain disability benefits with the help you will find here. We recognize, however, that people applying for disability benefits are most often ill or injured in a way that makes it difficult to accomplish the tasks of daily life, let alone pursue a claim for support from the government. So you may need help beyond this book. We have included an entire chapter on what to do if you need assistance (Chapter 15). Also, throughout the book you will see references to issues that

may need the advice and support of a family member, a trusted friend, paid representative or attorney.

B. Medical and Legal Questions

When deciding on your disability claim, the government considers both legal and medical issues. Social Security officials review your claim to decide whether you are legally entitled to the benefits you request. They also request and review medical opinions on your condition to see if it is severe enough to make you disabled. The government only considers you disabled if you are not able to work in your current or most recent job or you do not have the education, experience or ability to do any job. For example, a physically disabled 60-year-old doctor may have the ability to work in some other capacity in the medical industry and could be denied benefits for that reason. But the same doctor could not work as a field laborer picking fruit all day because he would not have the physical ability necessary for the job.

Chapters 1 through 15 lead you through the legal and practical issues of applying for disability payments, appealing if you are denied and making sure that you retain benefits as long as you need them. For most applicants it will be useful to read all of these chapters in the order presented. But if you have a particular issue to research (for example, you want to file an appeal) you can start with any chapter and you will be directed to important information in other parts of the book as needed (see Section C, below). Also note that we occasionally give you references to the Social Security portions of the Code of Federal Regulations, or C.F.R., or to the federal law or U.S. Code (U.S.C.).

Chapters 16 through 29 discuss the specific medical disabilities that make individuals eligible for disability payments. The SSA calls these the Listing of Impairments. You need not read each of these chapters; they are more like an encyclopedia. Once you find the section that matches or most closely approximates your disability, you will find all the medical information you need to determine if your disability meets the requirements to obtain benefits.

For example, if you suffer from kidney disease, you would turn to Chapter 21 and read through the listings

there until you found a disorder that matched or was similar to your illness.

Each of these medical chapters begins with a list of medical definitions in plain English related to the disorders discussed in the chapter. Following the definitions is a section containing background general information about the disorders discussed in the chapter.

Finally, each chapter has listings of specific medical disorders taken from the official Listing of Impairments used by the SSA in disability claims. The number before each listing is the official number used by the SSA to identify the disability. Following the numbers is a brief discussion of the meaning and how to interpret each listing. Chapters 16 through 29 contain every listing approved by the SSA for disability claims. The wording of the listings have, in many cases, been revised to make them more understandable. However, disability regulations are highly specific and no changes were made that would compromise their legal meaning.

Also included in each listing are comments about what the SSA calls Residual Functional Capacity, or RFC. This is a type of rating given to a disability claimant who does not meet the requirements of a Listing of Impairment. The RFC says what kind of work a claimant could do, even considering their impairments. If no work is available anywhere in the U.S. that fits into their RFC, they may be approved for disability payments even though their condition does not exactly fit the listing.

C. How to Use This Book

Everyone should read Chapter 1—What Is Social Security Disability? This chapter provides important background information that will be useful in all the chapters that follow. Once you grasp the basic information in Chapter 1, you will find the rest of the book much easier to understand.

Other chapters deal with specific procedures or rules, depending on individual circumstances. Start at the chapter in parentheses if you are interested in:

- applying for disability benefits (Chapter 2)
- applying for children (Chapter 3)
- getting benefits immediately (Chapter 4)
- how to prove you are disabled (Chapter 5)
- how claims are decided (Chapters 6 and 7)
- how to keep your benefits once you get them (Chapters 10 and 14)
- what to do if you have been denied benefits (Chapters 11 and 12), or
- finding someone to help you (Chapter 15).

Each chapter will direct you to other sections of the book that you will need to read to complete the task.



Throughout this book you will see samples of Social Security Administration forms. These are to help you fill out the actual forms. But the SSA requires that you obtain the forms from a Social Security office either in person, by mail or from the SSA website (www.ssa.gov). Throughout the book we tell you where to locate the forms you need.

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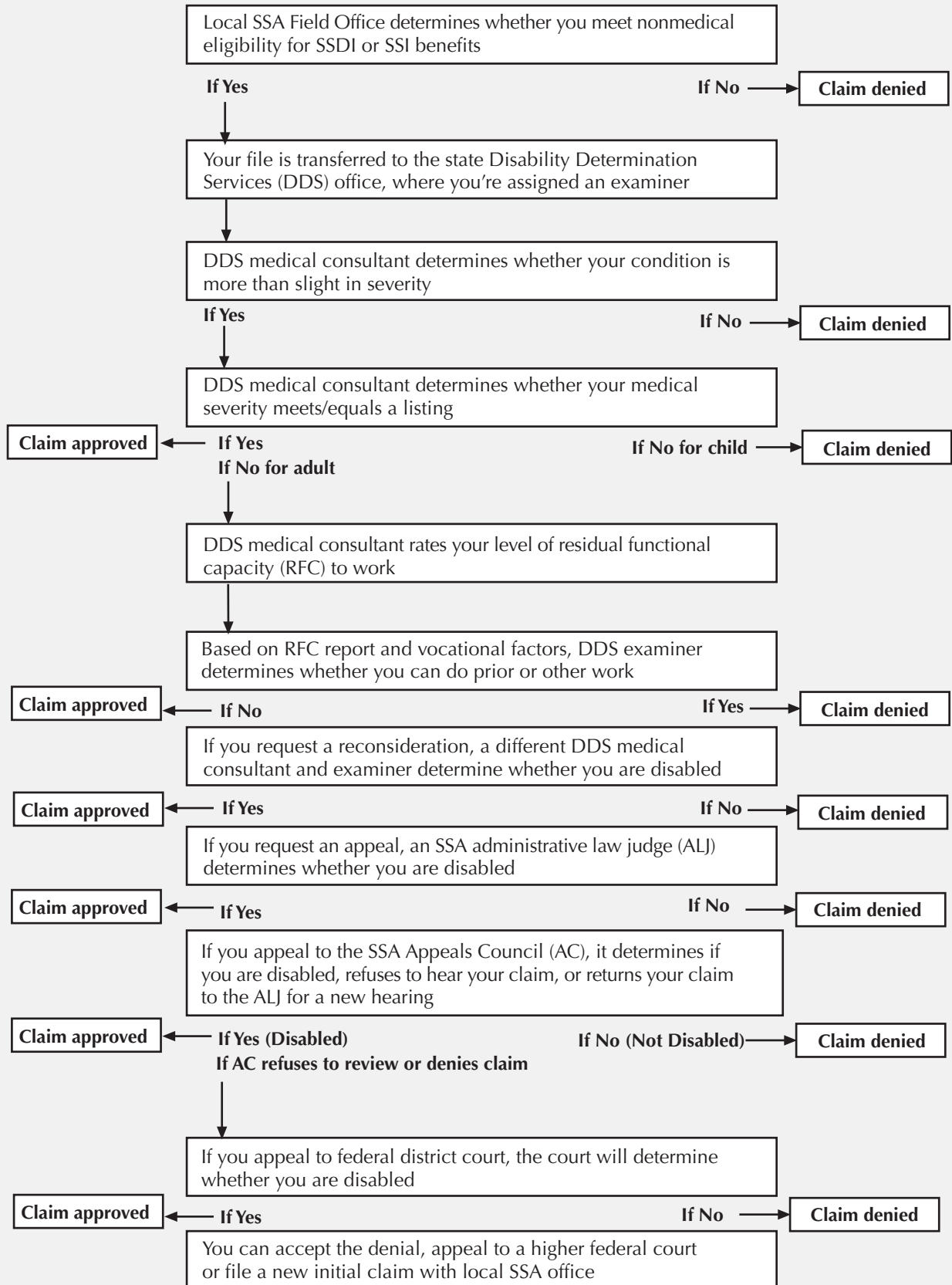


This icon indicates when you should consider consulting an attorney or other expert.



This icon tells you when you can skip reading a particular section or chapter.

How Claims Are Decided



Chapter 1

What Is Social Security Disability?

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The Social Security Administration (SSA) decides who is eligible for disability payments under rules established in the Social Security Act by the U.S. Congress. In this chapter we describe the two main SSA programs that administer disability payments. We briefly explain the requirements that any claimant must meet to receive benefits. We also provide a number of tips on how to deal with the SSA bureaucracy, including answers to some of the most frequently asked questions about Social Security Disability.

A. Two Different Programs

Once you qualify as disabled under the Social Security Act, the SSA makes disability payments under one of two programs:

- Social Security Disability Insurance (SSDI), for workers who have paid into the Social Security trust fund (and their dependents), and
- Supplemental Security Income (SSI), for disabled individuals with limited incomes and assets (and their dependents).

SSDI claims are also referred to as Title 2 claims because they are authorized under Title 2 of the Social Security Act. SSI claims may be referred to as Title 16 claims because they are authorized under Title 16 of the Social Security Act. A person claiming a disability is called a *claimant*. Some claimants apply under both Title 2 and Title 16; these are known as *concurrent claims*.

When the SSA receives your application, it will determine whether you are eligible for disability benefits under SSDI or SSI, even if you have not specifically requested both. This means that if you apply only for SSDI benefits, the SSA will automatically process your claim for any SSI disability benefits to which you might be entitled. If your SSDI claim is turned down, you don't have to file another claim for possible SSI benefits.

1. Social Security Disability Insurance

SSDI provides payments to workers who have made contributions to the Social Security trust fund through the Social Security tax on their earnings. SSDI is also

available to certain dependents of workers. If you are found eligible for SSDI, you might be entitled to back benefits if you can show that you were disabled before the date of your application. (See Chapter 10 for more details on when benefits begin.)

a. Who Qualifies?

To qualify for SSDI, you must fall into one of the following categories:

i. You are a disabled insured worker under age 65

You must have worked both long enough and recently enough to qualify. It may not be sufficient that you worked for many years and paid Social Security taxes. When you worked is also important. The law requires that you earn a certain number of work credits in a specified time before you apply for benefits. You can earn up to four credits per year, each credit representing three months. The amount of earnings required for a credit increases each year as general wage levels rise.

The number of work credits needed for disability benefits depends on your age when you become disabled. Most people need at least 20 credits earned over ten years, ending with the year you become disabled. Younger workers may qualify with fewer credits.

In effect, you count backwards from the year that you became disabled to see whether you have the appropriate number of credits. That means that credits from many years before you became disabled are automatically wiped out, or expire. This can lead to a dangerous situation for people who haven't worked for many years before becoming disabled. Their credits may dip below the required amount, and they can lose eligibility for SSDI. The date on which they lose their eligibility is called the "date last insured," or DLI—often a subject of dispute in Social Security cases. If you think your DLI is too far in the past to qualify you for SSDI, talk to your local SSA Field Office to make sure—in certain rare circumstances, you may still qualify.

The rules are as follows:

- **Before age 24**—Six credits earned in the three-year period ending when your disability started.

- **Age 24 to 31**—Credit for having worked half the time between age 21 and the time you become disabled. For example, if you become disabled at age 27, you would need credit for three years of work (12 credits) during the six years between ages 21 and 27.
- **Age 31 or older**—In general, you will need the number of work credits shown in the chart below. Unless you are blind (see Chapter 17 for definitions of legal blindness), at least 20 of the credits must have been earned in the ten years immediately before you became disabled.

Born after 1929 and became disabled at age:	Credits needed
31 through 42	20
44	22
46	24
48	26
50	28
52	30
54	32
56	34
58	36
60	38
62 or older	40



You can find out how many credits you have by contacting your local SSA office or, if you have access to the Internet, by filling out a form at www.ssa.gov/mystatement.

ii. You are the family member of an eligible worker

The SSA pays *auxiliary benefits* to people who qualify based on certain family members' entitlement to retirement or disability benefits. Benefits are paid based on the earnings records of the insured worker who paid enough Social Security taxes. If you qualify for auxiliary benefits, you do not necessarily have to be disabled; nor do you need the work credits described above.

Spouse's and divorced spouse's benefits. To qualify for auxiliary benefits as a spouse or divorced spouse, one of the following must apply (42 U.S.C. § 402(b) (c) (e) (f); 20 CFR §§ 404.330-349):

- You are the divorced spouse of a retired or disabled worker who is entitled to benefits, you

are 62 years old or older and you were married to the worker for at least ten years.

- You are the divorced spouse of a worker insured under SSDI who has not filed a claim for benefits, you are age 62 or older, your former spouse is aged 62 or older, you were married for at least ten years and you have been divorced for at least two years.
- You are a disabled widow or widower, at least 50 years of age but less than 60 years old, and you are the surviving spouse of a worker who received Social Security disability or retirement benefits.
- You are the surviving spouse (including a surviving divorced spouse) of a deceased insured worker, and you are age 60 or older.
- You are the surviving spouse (including a surviving divorced spouse) of a deceased insured worker, you care for a child of the deceased entitled to benefits who either is under age 16 or has been disabled since before age 22. (These benefits are known as "mother's or father's benefits.")

Child's benefits. A dependent, unmarried child is entitled to child's insurance benefits on the Social Security record of an insured parent, or deceased parent who was insured at death, if any of the following apply (42 U.S.C. § 402(d); 20 CFR §§ 404.350-369):

- The child is under age 18.
- The child is age 18 or 19 and a full-time student.
- The child is an adult and has been disabled since before age 22.

(See Chapter 3 for a more detailed discussion of benefits for children.)

Parent's benefits. You may qualify for parent's benefits if all of the following are true (42 U.S.C. § 402(h); 20 CFR §§ 404.370-374):

- Your child was an insured worker who died.
- You are at least 62 years old.
- You are divorced, widowed or unmarried and have not married since your child's death.
- You were receiving at least one-half of your support from your child at the time of death.
- You can provide evidence of this support within two years of the death (you may be exempt from providing evidence if unusual circumstances, such as extended illness, mental or physical

incapacity or language barrier, show that you could not have reasonably known of the two-year rule).

Lump-sum death benefits. A lump-sum death payment of several hundred dollars may be paid to the surviving spouse of an insured worker, if the survivor was living in the same household as the deceased at the time of death. You must apply for this benefit within two years of the insured worker's death. (42 U.S.C. § 402(i); 20 CFR §§ 404.390-395.)

Disability Freeze on Earnings

Federal laws and regulations recognize that your income may have declined between the period when you worked and when you stopped working because of your disability. Because your SSDI benefits depend on your earnings, the SSA recognizes that it is usually to your advantage to have your earning record "frozen" to reflect the higher income before you were disabled. Therefore, the SSA will exclude from your benefit calculations low income quarters of earnings resulting from a period of disability, unless it's to your financial advantage to include those quarters. (42 U.S.C. §§ 423(a), 426(b)(f); 20 CFR § 404.320.)

b. Citizenship or Residency Requirements

If you qualify based on the criteria listed above, you may receive SSDI payments if you are a U.S. citizen or permanent resident, living in the United States or abroad. If you are neither a citizen nor a permanent resident, you still may be entitled to receive SSDI if you can show that you are lawfully present in the United States. (8 U.S.C. § 1611(b)(2).)

If you are a citizen when you apply for SSDI, you will have to show proof of your citizenship. Acceptable forms of proof include a birth certificate showing birth within the United States or any of the following:

- Forms N-550 and N-570 (Certificate of Naturalization issued by the Immigration and Naturalization Service (INS))
- U.S. passport issued by the U.S. State Department

- Form I-197 (U.S. Citizen Identification Card issued by the INS)
- Form FS-240 (Report of Birth Abroad of a Citizen of the U.S. issued by the U.S. State Department)
- Form FS-545 (Certification of Birth issued by a foreign service post)
- Forms N-560 and N-561 (Certificate of Citizenship issued by INS), or
- Form DS-1350 (Certification of Report of Birth issued by the U.S. State Department).

If you are a permanent resident or resident alien, you will have to show that you are lawfully in the United States under one of the following conditions:

- lawful admission for permanent residence
- admission as a refugee or conditional entrance as a refugee
- asylum status or pending application for political asylum
- parole status
- deportation withheld or pending application for withholding of deportation
- member of a class of aliens permitted to remain in the United States for humanitarian or other public policy reasons, or
- you have been battered or subjected to cruelty by a family member while in the United States.

Most foreign workers in the United States are covered under the U.S. Social Security program and can potentially qualify for disability benefits. If, however, you are neither a citizen nor a permanent resident, you still may be covered under Social Security Disability. Federal law generally requires that all workers should pay Social Security taxes, and therefore be covered under SSDI for services performed in the United States. This is true even if they are nonresident aliens or employees who work here for short periods.

There are a few exceptions, however. Some non-immigrant foreign students and exchange visitors temporarily working in the United States may be exempt from paying Social Security taxes and therefore would not qualify for disability benefits under SSDI if they became disabled.

Noncitizen or permanent residents of the United States who are entitled to SSDI may be paid benefits while they reside abroad, depending upon their citizenship status and the countries in which they live. However, with some exceptions, an alien beneficiary

who leaves the United States must either return to the U.S. at least every 30 days or for 30 consecutive days during each six-month period, in order to continue to draw benefits. One exception is made for alien beneficiaries who are on active military duty for the United States. Another exception exists for alien beneficiaries who live in and are citizens of Germany, Greece, Ireland, Israel, Italy or Japan. (The United States has treaty obligations with these nations to continue paying benefits regardless of how long beneficiaries are outside the United States.) Citizens of the Netherlands may receive partial benefits. (See Chapter 13 for more information about receiving benefits outside of the United States.)



Be aware of restricted countries. There are a few countries where residents cannot receive benefits even if they otherwise qualify. These include Cuba, North Korea and Vietnam.

International Social Security Agreements

The United States has entered into several International Social Security agreements called totalization agreements, which have two major purposes. First, they eliminate dual Social Security taxation, the situation that occurs when a worker from one country works in another country and is required to pay Social Security taxes to both countries on the same earnings. Second, the agreements help fill gaps in benefit protection for workers who have divided their careers between the United States and another country. The United States has totalization agreements with Australia, Austria, Belgium, Canada, Chile, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, South Korea, Spain, Sweden, Switzerland and the United Kingdom. (42 U.S.C. § 433.)

2. Supplemental Security Income (SSI)

The SSI program provides payments to an adult or child who is disabled and has limited income and resources. If your income and resources are too high, you will be turned down for benefits no matter how

severe your medical disorders. You will be turned down even if you have not paid enough in Social Security taxes to qualify for SSDI.

The SSI limits on income and resources is one of the most complicated areas handled by the SSA. Although important points are covered here, only representatives of the SSA can accurately determine your income and resources for purposes of qualifying for SSI.

a. Income Limits

To qualify for SSI, your monthly income (as counted by the SSA) cannot exceed something called the federal benefit rate (FBR). The FBR for a married couple is approximately 50% more than for an individual. If only one member of a couple is eligible, both spouses' income is still considered. If a child under age 18 is living with parents, then the parents' income is considered. The FBR is set by law. It increases annually as dictated by cost-of-living adjustments. For example, in 2002 the FBR was \$545 per month for an individual and \$817 per month for a married couple. In 2003, a cost of living adjustment (COLA) of 1.4% raised the FBR to \$552 per month for individuals and \$829 for couples.

The federal benefit rate sets both the SSI income limit and the maximum federal SSI payment. The FBR payment is supplemented in every state except Arkansas, Georgia, Kansas, Mississippi, Tennessee, Texas and West Virginia. In all other states, the allowed income level and the SSI payments are higher than the federal maximums. In California, Iowa, Massachusetts and Nevada, the state supplements are higher for blind recipients than for others. Also, the amount of the state supplement depends on whether you are single or married and on your particular living arrangements. Although the amount of the state supplement varies widely, it can be as much as several hundred dollars.

The SSA does not count the following income and benefits when calculating your income level:

- \$20 per month of most income, except wages
- \$65 per month of wages and one-half of wages over \$65
- food stamps, and
- home energy and/or housing assistance.

(See Chapter 13 for more detailed information in income limitations.)

b. Resource Limits

To qualify for SSI, your resources must also not exceed certain limits. A “resource” is cash or another asset that can be converted to cash and used for support. If you or your spouse have the right, authority or power to sell property and keep the proceeds, it will be considered a resource.

Resources are categorized as either liquid or nonliquid. Liquid resources include cash and other assets that could be converted to cash within 20 working days. The most common types of liquid resources are savings and checking accounts, stocks, bonds, mutual funds, promissory notes and certain types of life insurance. Nonliquid resources cannot be converted to cash within 20 working days. They include both real property (land) and personal property. Some resources may be considered by SSA to be both liquid and nonliquid (such as an automobile or life insurance policy).

Conditional Payments

It's possible that you don't qualify for SSI benefits, but might be entitled to conditional payments—in essence, a loan. This happens when your resources are above the resource limits, but include nonliquid assets that may take months for you to convert into cash in order to use as support. In that situation, the SSA will make conditional payments until you sell your assets and can support yourself. You will not receive SSI—and you must refund to the SSA the amount you received at the end of the conditional payment period.

The resource limits are set by law. They are not subject to regular cost-of-living adjustments, but they have increased slowly over the years. For 2003, you will not be eligible for SSI disability payments if your assets exceed:

- \$2,002 for a single person, or
- \$3,000 for a married couple (even if only one member is eligible for SSI).

When counting up your assets, the SSA must exclude certain assets, including the following:

- your home (including adjacent land and related buildings), regardless of value. The home must be owned by you or your spouse and used as your principal residence.
- restricted allotted Indian lands
- household goods and personal effects up to \$2,000 in value
- one wedding ring and one engagement ring of any value
- necessary health aids, such as a wheelchair or prosthetic device
- one automobile, regardless of value, if used to provide necessary transportation; if not used for that purpose, then one automobile up to \$4,500 in value
- nonbusiness property needed for support, up to a reasonable value
- resources of a blind or disabled person needed to fulfill an approved plan for achieving self-support (called a PASS plan). (See Chapter 13 for more information.)
- life insurance with a face value of \$1,500 or less
- burial plots and certain burial funds up to \$1,500
- disaster relief, and
- housing assistance paid under the U.S. Housing Act, the National Housing Act or the Housing and Urban Development Act.



Exceptions to the residence requirements often involve complex legal issues, and you are probably best off consulting an attorney if you think one might apply to you.

c. Citizenship and Residency Requirements

SSI disability payments are usually available only to U.S. citizens. There are several exceptions, however, under which noncitizens might be eligible, including the following:

- During the first seven years after you were admitted, you are either legally residing in the United States as a refugee, have been granted asylum, satisfy certain conditions of withheld deportation, have been granted status as a Cuban or Haitian entrant or, under some conditions,

Comparing SSDI and SSI		
	SSDI (Title 2)	SSI (Title 16)
Must have paid Social Security tax to qualify?	Yes	No
Disability benefits for children?	Only adult children at least 18 years of age and disabled before age 22	Children of any age
Waiting period before benefits begin?	Adults: Five months Children: None	No
Health insurance comes with disability award?	Yes. Medicare starts 24 months after waiting period.	Yes. Medicaid starts immediately in most states.
Can be presumed disabled before actual approval of benefits?	No	Yes, up to six months before decision. Claimant does not have to return payments if found not disabled.
Retroactive benefits?	Yes. Up to 12 months	No
Minimum duration of disability?	12 months	12 months. Blind claimants are exempt from duration requirement
What financial factors may prevent eligibility for benefits?	Substantial Gainful Activity: Work earning more than \$800/month (\$1,330/month if blind) as of year 2003	a. Substantial Gainful Activity b. Nonwork income and other resources equivalent to income
Benefits to noncitizens in U.S.?	Yes	Generally not, but some exceptions
Possible freeze on earnings?	Yes	No
Benefits for past period of disability ("closed period"), even if not currently disabled?	Yes	Yes
Auxiliary benefits to others available on the work earnings of a relative or spouse?	Yes	No
Benefits continued during a period of trial work?	Yes	No
Quick re-entitlement to benefits if work effort fails after termination of benefits	Yes	Yes
Benefits outside of U.S.?	Yes, both U.S. citizens and noncitizens	Generally not for U.S. citizens; never for noncitizens

entered as an Amerasian immigrant. (8 U.S.C. § 1612(a)(2)A)(i)(I-V).)

- You legally entered the United States for permanent residence and have worked 40 qualifying quarters under the Social Security Act (see Section A1a, above). In some situations, you may be able to count the qualifying quarters of a parent (for the time you were under age 18) or a current spouse or deceased spouse. (8 U.S.C. § 1612(a)(2)(B).)
- You were honorably discharged from the U.S. military, you are on active duty in the U.S. military, or you are the spouse of a veteran or person on active duty, the unmarried dependent child of a veteran or person on active duty or the surviving spouse of a deceased veteran or person on active duty and you have not remarried. (8 U.S.C. § 1612(a)(2)(C)(i-iii).)
- You were lawfully residing in the United States and receiving SSI benefits on August 22, 1996. (8 U.S.C. § 1612(a)(2)(E).)
- You were lawfully residing in the United States on August 22, 1996, and you are blind or otherwise became disabled at any time. (8 U.S.C. § 1612(a)(2)(F).)
- You are lawfully residing in the United States and are an American Indian born in Canada. (8 U.S.C. § 1612(a)(2)(G).)
- You have been battered or subjected to cruelty in the United States by a family member. (See Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended by P.L.104-208, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 and P.L. 105-33, the Balanced Budget Act of 1997.)

d. Receiving Benefits When Outside of the U.S.

SSI payments are generally only available to people residing in the 50 states, District of Columbia or Northern Mariana Islands. If you receive SSI disability benefits and move, for example, to Mexico or Puerto Rico, you will lose those benefits. There are a few exceptions for some U.S. citizen children and students:

- A blind or disabled child may be eligible for SSI benefits while outside the United States if the

child is a U.S. citizen, lives with a parent who is a member of the U.S. armed forces assigned to permanent duty outside the United States and was eligible to receive SSI benefits in the month before the parent reported for duty abroad.

- A student of any age may be eligible for SSI benefits while temporarily outside the United States for the purpose of engaging in studies not available in the United States sponsored by an educational institution in the United States and designed to enhance the student's ability to engage in gainful employment. The student must have been eligible to receive SSI benefits in the month preceding the first full month abroad.

B. Defining Disabled

For adults and children applying for SSDI and for adults applying for SSI, being disabled means that you are unable to engage in any substantial gainful activity because of a medically determinable physical or mental impairment. The disability must have lasted or be expected to last for a continuous period of at least 12 months, or be expected to result in death.

For children applying for SSI, being disabled means the child has a medically determinable physical or mental impairment that causes marked and severe functional limitations. The limitations must have lasted or be expected to last for a continuous period of at least 12 months, or be expected to result in death.

Let's break these concepts down further.

1. Inability to Engage in Substantial Gainful Activity

Inability to engage in *substantial gainful activity* (referred to as the *SGA requirement*) means that if you work, you do not earn more than a certain amount of money. For nonblind people, the 2003 amount is \$800 per month. For blind people, the amount is \$1,330 per month in 2003 and is adjusted annually. If you ever need to find out the SGA income limit for a given year, simply call a local SSA office. (See Section C, below.)

Even if you have an impairment that meets the requirements for disability, you won't qualify for SSDI or SSI if you earn more than the SGA level. In this situation, if you stop working and apply for disability payments, you must be able to show that your medical condition became worse or that special help you required to do your job was no longer available. The SSA is very lenient in this regard, if you make it clear that you had to stop working because of your medical problems. If you say you stopped working without a medical reason, you might not qualify to receive benefits.

SGA refers only to money you obtain from working, not money you obtain from other sources, such as investments or gifts.

2. Medically Determinable Impairment

A medically determinable physical or mental impairment is a disorder (abnormal condition) that results from anatomical (body structure), physiological (body function) or psychological (mental) abnormalities which can be proved by medically acceptable clinical and laboratory diagnostic techniques. The Social Security Act requires that a physical or mental impairment be established by medical evidence consisting of signs (objective findings by a medical provider), symptoms (subjective complaints by you) and laboratory findings.

In other words, the SSA must be able to determine that you have something wrong with you, either physically or mentally. To make such a decision, the government can ask to examine your treating doctor's records and your hospital records, order x-rays or other tests as needed, or have you examined by a doctor of its choosing if your records are incomplete or too old. Symptoms such as pain are important, but alone cannot get you benefits. They must be linked to some physical or mental problem. In addition, your statement alone that you have symptoms is not sufficient. A doctor must show that you have a physical or mental condition that could cause the symptoms you say you have.

Pain and Other Symptoms

Your pain and symptoms are important parts of your disability claim. SSA staff frequently hand out forms that allow you to describe your pain and symptoms in your own words. For example, you might be asked to say where you have pain, what it feels like, what activities cause it or make it worse, and how long it lasts. In addition, you might be asked what medications you are taking and what side effects they may be causing. In fact, you should be asked these questions at some point during the claims process because federal law requires that the SSA consider your allegations of pain and other symptoms in reaching a decision. Pain and other symptoms are considered more fully in Chapter 5.

3. Duration of Disability

Your impairment must be severe enough to disable you (according to the SSA's medical criteria) for at least 12 continuous months or to result in your death. The 12-month duration requirement does not mean that you must have been severely ill for a year before applying for benefits. The SSA often presumes that an impairment will last a year when it has not improved after three months. If an impairment is obviously long-lasting and very severe, the SSA can make an immediate determination. For example, if your spinal cord was cut in half in an automobile accident, you will, at the very least, be unable to walk for the rest of your life. There would be no reason for the SSA to wait before approving your claim, assuming you otherwise qualify.

The SSA includes the possibility of death in the definition of disability because death is the most extreme disability possible. Nothing in the Social Security Act specifies how to measure the possibility of death. But the SSA does provide some guidance. If you meet the criteria of any of the cancer listings, the SSA presumes you cannot work, based more on a poor prognosis than on an inability to do work. These cancer prognoses include a median life expectancy of 36 months. (See Chapter 28 for more on cancer listings and the definition of median life expectancy.) Sometimes, the SSA uses the same survival probabilities in

deciding noncancer disabilities that might result in death. These estimates can be difficult to make and require medical knowledge.

Many people apply for disability after acute injuries or impairments that won't produce any long-term effect severe enough to qualify for benefits. If you have any question in your mind about how long your impairment will last, apply for benefits. This is especially true if you are over 50 years old. Older people do not need as severe an impairment as people under 50 to be allowed benefits. You can also ask your doctor's opinion about how long your illness will last. But it will be up to the SSA to decide whether you meet the minimum duration requirement of 12 months. In some cases, the SSA might think your impairment will last long enough, even if your doctor does not.

There is one exception to the duration of disability requirement: SSI claims based on blindness have no duration requirement.

C. Contacting the Social Security Administration

The SSA is headed by a commissioner. The commissioner, administrative offices and computer operations are located in Baltimore. The SSA discourages visits to this central office regarding individual claims because service can be provided by local offices.

Local Social Security offices are where you can apply for:

- Social Security benefits
- SSI, black lung benefits and hospital insurance protection, and
- a Social Security number.

You can also:

- check on your earnings record
- enroll for medical insurance
- receive assistance in applying for food stamps
- get information about your rights and obligations under the law, and
- obtain forms you need to apply for or maintain benefits or appeal SSA decisions.

There is no charge for these services. Employees of the SSA are public servants paid by your tax dollars. They are obligated to be helpful and courteous. If you encounter someone who is not helpful and courteous,

ask to talk to his supervisor. Usually, this will cause him to immediately change his attitude, because complaints might affect his job performance ratings and ultimately his promotions or income. If it is necessary, insist on speaking to the supervisor. Supervisors are usually very interested in working out problems. A request to talk to the supervisor's supervisor is rarely necessary. If you feel you have been treated really badly, you can contact your local U.S. congressperson or senator. They will send a "Congressional inquiry" to the SSA. The SSA is very sensitive to public relations, and inquiries by Congress often get results if the complaint has merit.

Local Social Security offices exist in large cities of every state, and in bureaucratic language are known as *Field Offices*. Social Security office staff make regular visits to outlying areas to serve people who live a distance from the city in which the local office is situated. These visits are made to locations called *contact stations*. You can obtain a schedule of these visits from your local Social Security office. Some contact stations are visited twice a week, while others may be visited only once or twice a month.

If you are denied SSDI or SSI, you can appeal that decision. (Appealing is discussed in Chapter 12.) The Office of Hearings and Appeals administers the entire hearings and appeals program for the SSA. Administrative law judges, located in or traveling to major cities throughout the United States and its territories, hold hearings and issue decisions when a claimant appeals a determination. The Appeals Council, located in Falls Church, Virginia, can review hearing decisions.

You can reach a live service representative by calling the SSA hotline at 800-772-1213, Monday through Friday (except holidays), from 7 a.m. to 7 p.m. If you are deaf or hard of hearing, TTY service representatives are available at the same times at 800-325-0778. All calls are confidential. After hours, you can obtain pre-recorded information on a variety of topics.

SSA representatives can direct you to the Social Security office nearest you, as well as answer numerous other questions. Once you have made contact with your local SSA Field Office, you will deal with them rather than using the hotline. On the Internet, information about Social Security is at www.ssa.gov.

The SSA's phone lines are busiest early in the week and early in the month; if your business can wait, call at other times.

Have the following items handy when you call:

- your Social Security number
- a list of questions you want to ask
- any recent correspondence you received from the SSA, and
- a pencil and paper to write down information and answers to your questions. Always write the date you called.

D. Frequently Asked Questions About Social Security Disability

Following are some frequently questions asked about SSDI and SSI.

1. How is the disability determination made?

The SSA disability evaluation is made under a procedure known as the sequential evaluation process. For adults, this process requires step-by-step review of your current work activity, the severity of your impairment, your remaining physical and mental abilities, your past work and your age, education and work experience.

For children applying for SSI, the process requires sequential review of the child's current work activity (if any), the severity of his or her impairment and an assessment of whether the impairment results in marked and severe functional limitations. (The sequential evaluation process is discussed in Chapter 7.)

2. When do disability benefits start?

SSDI claimants may be entitled to retroactive (past) benefits, if they are found to have been disabled before their application date. Actual payments, however, cannot be made until five months pass from the date of the onset of disability. Cash benefit payments cannot be paid retroactively to cover more than 12 months before the application date—no matter how severe your disability.

There are exceptions to the five-month waiting period requirement. These exceptions, along with more detailed information about onset can be found in Chapter 10.

Under SSI, disability payments may begin as early as the first day of the month after an individual files an application, but no earlier. In addition, under the

SSI program, you may be found “presumptively disabled” and receive cash payments for up to six months while the formal disability determination is made. The presumptive payment is designed to allow a needy person to meet his or her basic living expenses during the time it takes to process the application. If a claimant is denied SSI benefits, he or she is not required to refund the payments.

3. What if I disagree with the determination?

If you disagree with the initial determination, you can appeal. The first appeal is called a reconsideration, which is generally a review of your case by a team that was not involved in the original determination. If your case is denied on reconsideration, you can request a hearing before an administrative law judge. If you are dissatisfied with that decision, you can ask for a review by the SSA Appeals Council.

If you exhaust all administrative appeals but wish to continue pursuing the case, you can file a civil lawsuit in federal district court and eventually appeal all the way to the U.S. Supreme Court. (Appeals are covered in Chapter 12.)

4. Can I receive disability benefits or payments while getting Medicare or Medicaid coverage?

Yes. Medicaid and Medicare are our country's two major government-run health insurance programs. Generally, people on SSI and other people with low incomes qualify for Medicaid, while Medicare coverage is earned by working in jobs covered by Social Security, the Railroad Retirement Act or for the federal government. Many people qualify for both. If you receive Medicare or Medicaid along with your disability benefits, you do not have to do anything special or additional to obtain such coverage once you have qualified for disability. You don't have to write any letters or fill out any more forms. If and when you qualify for such coverage, the federal government will send you what you need.

SSDI claimants granted disability benefits qualify for Medicare coverage. The coverage doesn't start for two years from the onset of disability—and that means two years starting after the initial five-month waiting period. Therefore, you may be left without medical insurance coverage for several years if you don't have some other type of coverage or are not poor enough

to qualify for SSI Medicaid coverage. There are three exceptions to the two-year rule:

- If you have end-stage renal disease with kidney failure and you require dialysis or a kidney transplant, coverage by Medicare can begin the third month after the month in which dialysis began.
- If you are terminally ill with a life expectancy of six months or less and receive hospice care, coverage by Medicare can begin immediately.
- Individuals with amyotrophic lateral sclerosis (ALS) qualify for Medicare as soon as they qualify for benefits.

If you get Medicare and have low income and few resources, your state may pay your Medicare premiums and, in some cases, other out-of-pocket Medicare expenses such as deductibles and coinsurance. Only your state can decide if you qualify. Contact your local welfare office or Medicaid agency. For more general information about Medicare, contact a local SSA office or look for *Medicare Savings for Qualified Beneficiaries* on the SSA's website, www.ssa.gov.

SSI claimants granted disability qualify for Medicaid coverage in most states. Where available, Medicaid coverage starts immediately. Only 16 states have no medically needy programs for their aged, blind and disabled. The 16 states are Alabama, Alaska, Arizona, Colorado, Delaware, Idaho, Indiana, Mississippi, Missouri, Nevada, New Mexico, Ohio, South Carolina, South Dakota, Texas and Wyoming.

5. Can I work and still receive disability benefits?

Social Security rules make it possible for people to test their ability to work without losing their rights to cash benefits and Medicare or Medicaid. These are called work incentives. The rules are different for SSDI and SSI, but under both programs, you can receive:

- continued cash benefits
- continued help with medical bills
- help with work expenses, or
- vocational training.

For more information about work incentives, contact a local SSA office or look for *A Summary Guide to Social Security and Supplemental Security Income Work Incentives for People With Disabilities* on the SSA's website, www.ssa.gov. (Work incentives are discussed in Chapter 13.)

6. How can I receive vocational training services?

Claimants for SSDI or SSI may be referred to a state vocational rehabilitation agency for rehabilitation services. The referral may be made by the DDS (see Chapter 6), the SSA, a treating source or personal request. The services may be medical or nonmedical and may include counseling, teaching of new employment skills, training in the use of prostheses and job placement. In determining whether vocational rehabilitation services would benefit you in returning to work, medical evidence from your treating source may be very important.

7. I understand that to get disability benefits, my disability must be expected to last at least a year. Does this mean that I must wait a year before I can get benefits?

You do not have to wait a year after the onset of the disability before you can get benefits. File as soon as you can after becoming disabled.

8. I have been receiving Social Security disability benefits for the past four years and my condition has not improved. Is there a time limit on Social Security disability benefits?

No. You will continue to receive a disability benefit as long as your condition keeps you from working. But, your case will be reviewed periodically to see if there has been any improvement in your condition and whether you are still eligible for benefits (see Chapter 14). If you are still eligible when you reach 65, your disability benefits will be automatically converted to retirement benefits.

9. I had a serious back injury four years ago and received disability benefits for about 18 months until I could return to work. Unfortunately, my back problems have recurred and I don't know how much longer I will continue working. When I initially applied for benefits, I waited several months before I received my first check. If I reapply for benefits, will my wait be as long as it was the first time?

Maybe not. It depends on what the new medical reports say and whether additional evidence is required. A worker who becomes disabled a second time within five years after benefits stop can have his or her checks start again, beginning with the first full month of disability if the new claim is approved.

10. My brother had an accident at work last year and is now receiving SSDI disability benefits for himself, his wife and daughter. Before his accident, he helped support another daughter by a woman to whom he has never been married. Is the second child entitled to some benefits as well?

Yes. Even though your brother was not married to the second child's mother, Social Security pays benefits to all of his children. Each child is entitled to equal benefits. ■

Chapter 2

Applying for Disability Benefits

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A. Preparing to Apply

You can play an active and important role in ensuring that your claim is processed accurately and quickly. The best advice is to keep thorough records that document the symptoms of your illness or injury and how it affects your daily activities before you apply. Then, provide this information to the Social Security Administration when you file your claim.

1. Document Your Symptoms Early and Often

Use a calendar to jot down brief notes about how you feel each day. Record any of your usual activities that you could not do. Be specific. Remember to include any psychological (emotional or mental) difficulties.

2. Help Your Doctor Help You

Not all doctors are aware of the kind of information the SSA needs to document a disability. Ask your doctor to track the course of your symptoms in detail over time and to keep a thorough record of any evidence of fatigue, depression, forgetfulness, dizziness and other hard-to-document symptoms. Note that by “doctor,” the SSA means a medical doctor or osteopath, also known as an *acceptable medical source*. (Acceptable medical sources are covered in Chapter 5.) If you don’t have a doctor, the SSA will have you examined at their expense.

3. Record How Your Condition Affected You on the Job

If you were working, but lost your job because of your illness or injury, make notes that describe what it is about your condition that forced you to stop working.

B. Applying for Disability Benefits

You can apply for disability benefits at a local Field Office or contact station. You do not have to call or

make an appointment to visit a Field Office or contact station, but it is advisable that you do. Otherwise, you might have to wait or come back another time.

When you arrive, tell the desk or counter clerk that you want to apply for disability benefits. You’ll be scheduled to meet an interviewer, who will inform you of your rights and responsibilities, assist you in completing your application and obtain information and evidence from you that is needed to determine your eligibility. Note the name of the specific person assigned to help you in case you need to later contact her for help. Bring reading materials with you. You may have a bit of a wait before you see the interviewer.

Applying Over the Phone

If you prefer, you can call the SSA at 800-772-1213 to file an application. This is especially convenient if you live some distance from the nearest Field Office or contact station (you can find the location of the nearest SSA facility by calling the 800 number listed above). If you need help, a family member, case-worker or other representative can contact the SSA for you. You do not have to give that person a power of attorney—the authority to sign legal documents and make legal decisions for you—to help you obtain an application form and file a claim.

If you cannot go to the Social Security office because of poor health or if there is no Social Security office nearby, you can get full information and application forms by making an appointment for a telephone interview. Even if you cannot get to the Field Office to file an application (due to illness, lack of transportation or whatever other reason), an SSA representative can do the interview over the telephone.



The Social Security Administration has a helpful website filled with useful information and up-to-date rules and regulations for disability claimants at www.ssa.gov.

You can speed up the processing of your claim by being as prepared as possible before contacting the

SSA Field Office. Remember that the SSA is a huge and complex bureaucracy that needs a lot of information about you. If you do some basic preparation, the whole process can proceed smoothly. On the other hand, do not wait until you have every conceivable detail ready for review before you contact the Field Office.

You are responsible for submitting the necessary evidence to support your claim of disability (see Chapter 5). The Social Security office will assist you by telling you what evidence is required to establish your claim and how you can obtain that evidence. If you can't get it, the Social Security office will offer special assistance, based upon your needs, to ensure the proper resolution of the claim. Never assume that the claims representative can read your mind if you have a special problem regarding your application. If you have some concern, mention it. SSA claims representatives are instructed to help you if they can reasonably solve a problem that is related to your application.

For example, if a claimant cannot read or write, the claims representative will provide assistance in completing the forms. In addition, the SSA Field Office will provide an interpreter if you need language assistance. The SSA uses whatever qualified interpreters or interpreter services are most appropriate to the situation and are most reliable and readily available.

Furthermore, the SSA maintains cooperative relationships with many groups and organizations that provide assistance with the application process. Each SSA office maintains a list of the agencies (both public and private) in the community and the types of services provided by each. If you inquire, you can immediately be referred to an agency providing the needed services.

If you are applying for adult disability, the SSA will send you Form SSA-3368-BK to begin the process. We include a sample form below. (If you are applying for a child, you will receive

Form SSA-3820-BK. See Chapter 3 for a sample of that form.)

When you arrive at the Social Security Field Office for an interview, the official will ask you many questions. Your answers will be put on either Form SSA-16-F6 (for disability insurance benefits) or Form SSA-8000-BK (for SSI benefits).

Take a look at the appropriate samples below before you head out to the Social Security office or have your interview. That way you can gather in advance as much information and paperwork as possible. Don't worry if you can't answer every question or find all documents; the claims representative or interviewer will help you. Realize, however, that if you don't have key information with you at the time of your interview (see just below), you might have to get it and send it in to the SSA office. This could delay the processing of your application.



You must use forms provided by the SSA. You can obtain them at your local SSA Field Office or by calling the SSA hotline at 800-772-1213, Monday through Friday (except holidays), from 7 a.m. to 7 p.m. If you are deaf or hard of hearing, TTY service representatives are available at the same times at 800-325-0778. You can also download many necessary forms from the Social Security Administration website at www.ssa.gov.



Form SSA-3368-BK, Disability Report—Adult (Page 1)

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579**DISABILITY REPORT
ADULT****For SSA Use Only**

Do not write in this box.

Related SSN _____

Number Holder _____

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON**A. NAME** (First, Middle Initial, Last)

William I. Hamilton

B. SOCIAL SECURITY NUMBER

999-99-9999

C. DAYTIME TELEPHONE NUMBER (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)312 555-2222
Area Code Number☒ Your Number☐ Message Number☐ None**D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries or conditions and can help you with your claim.**NAME Mildred PayneRELATIONSHIP CousinADDRESS Townhouse Apartments, #112, 456 Center St.

(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

Chicago IL 60692 DAYTIME 515 123-4567
City State ZIP PHONE Area Code Number**E. What is your height** without shoes?5 10
feet inches**F. What is your weight** without shoes?175
pounds**G. Do you have a medical assistance card?** (For Example, Medicaid or Medi-Cal) If "YES," show the number here:☐ YES ☒ NO**H. Can you speak English?** ☒ YES ☐ NO If "NO," what languages can you speak?If you **cannot speak English**, is there someone we may contact who speaks English and will give you messages? (If this is the same person as in "D" above show "SAME" here.)

NAME _____ RELATIONSHIP _____

ADDRESS _____

(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

City State ZIP DAYTIME PHONE Area Code Number**I. Can you read English?** ☒ YES ☐ NO **J. Can you write more than your name in English?** ☒ YES ☐ NO

Disability Report-Adult-Form SSA-3368-BK

Form SSA-3368-BK, Disability Report—Adult (Page 2)

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the **illnesses, injuries or conditions** that limit your ability to work? Arthritis
right shoulder, liver problems (cirrhosis), cataracts, nervous, back pain

B. How do your illnesses, injuries or conditions limit your ability to work? Hurts my
shoulder to lift, push, or pull. Feel weak, can't see well. Can't concentrate because of
nervousness. Back hurts to lift and bend.

C. Do your illnesses, injuries or conditions cause you **pain**? ☒ YES ☐ NO

D. When did your illnesses, injuries or conditions **first bother you**?

Month June	Day don't know	Year 2001
---------------	-------------------	--------------

E. When did you become **unable to work** because of your illnesses, injuries or conditions?

Month October	Day 12	Year 2003
------------------	-----------	--------------

F. Have you **ever worked**? ☒ YES ☐ NO (If "NO," go to Section 4.)

G. Did you **work at any time** after the date your illnesses, injuries or conditions first bothered you? ☒ YES ☐ NO

H. If "YES," did your illnesses, injuries or conditions cause you to: (check all that apply)

- ☒ **work fewer hours?** (Explain below)
- ☐ **change your job duties?** (Explain below)
- ☒ **make any job-related changes such as your attendance, help needed, or employers?** (Explain below)

I started missing days, then my sick leave was used up. My employer let me work
half days for a while, but it got to a point where I couldn't do that either.

I. Are you **working now**? ☐ YES ☒ NO

If "NO," when did you **stop working**?

Month October	Day 12	Year 2003
------------------	-----------	--------------

J. Why did you **stop working**? Weakness, pain, and other symptoms. As I said above,
I just couldn't do it anymore. My boss said he was sorry but others were spending too
much time doing my work for me, and he didn't have an other job I could do.

Form SSA-3368-BK, Disability Report—Adult (Page 3)

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List the **jobs** that you have had in the **last 15 years** that you worked.

JOB TITLE (Example, Cook)	TYPE OF BUSINESS (Example, Restaurant)	DATES WORKED (month & year)		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)	
		From	To				
Electrician Helper	Utility	9/1982	10/2003	8	5	\$ 18	hr
						\$	
						\$	
						\$	
						\$	
						\$	
						\$	

B. Describe the **job above** that you did the **longest**. (What did you do all day in this job?)

Only one job that lasted 15 years. Numerous duties, including assisting in installation and repair of electric power equipment, underground cable and related activities.

- C. In **this job**, did you:
- | | | |
|--|---|--|
| Use machines, tools or equipment? | ☒ YES | ☐ NO |
| Use technical knowledge or skills? | ☒ YES | ☐ NO |
| Do any writing, complete reports, or perform any duties like this? | ☐ YES | ☒ NO |
| Did you supervise other people? | ☐ YES | ☒ NO |
| If "YES," was this your main duty? | ☐ YES | ☐ NO |

D. In **this job**, how many total hours each day did you:

Walk? <u>6-8</u>	Kneel? (Bend legs to rest on knees.) <u>2-3</u>
Stand? <u>6-8</u>	Crouch? (Bend legs & back down & forward.) <u>2-3</u>
Sit? <u>0-1</u>	Crawl? (Move on hands & knees.) <u>2-3</u>
Climb? <u>3</u>	Handle, grab or grasp big objects? <u>6-8</u>
Stoop? (Bend down and forward at waist.) <u>3</u>	Write, type or handle small objects? <u>6-8</u>

E. **Lifting and Carrying** (Explain what you lifted, how far you carried it, and how often you did this.)

Heavy machine parts, electrical cable, worked with heavy equipment like transformers, rigged scaffolding & hoists. Carried heavy objects 50-1000 ft. most of day.

F. Check **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☒ 100 lbs. or more ☐ Other _____

G. Check weight **frequently** lifted: (By frequently, we mean from 1/3 to 2/3 of the workday.)

☐ Less than 10 lbs ☐ 10 lbs ☒ 25 lbs ☐ 50 lbs. or more ☐ Other _____

Form SSA-3368-BK, Disability Report—Adult (Page 4)

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

- A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☒ YES ☐ NO
- B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☒ YES ☐ NO

If you answered "NO" to both of these questions, go to Section 5.

- C. List **other names** you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

- D. List each **DOCTOR/HMO/THERAPIST**. Include your **next appointment**.

1. NAME	Dr. David Bates			DATES
STREET ADDRESS	2325 Front Street			FIRST VISIT
				August 2002
CITY	Chicago	STATE	IL	ZIP
				unknown
PHONE	312	555-1234	CHART/HMO #	
	Area Code	Phone Number	none	
REASONS FOR VISITS	Back and shoulder pain			
WHAT TREATMENT WAS RECEIVED? Steroid injection in shoulder; physical therapy for shoulder and back; drugs for pain				

2. NAME	Dr. Susan Hill			DATES
STREET ADDRESS	240 W. 8th Street			FIRST VISIT
				May 2002
CITY	Chicago	STATE	IL	ZIP
				60685
PHONE	312	555-2345	CHART/HMO #	
	Area Code	Phone Number	none	
REASONS FOR VISITS	Nervousness			
WHAT TREATMENT WAS RECEIVED? Talk; tranquilizer drugs for nervousness				

Form SSA-3368-BK, Disability Report—Adult (Page 5)

SECTION 4—INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST

3. NAME Dr. John Simmons			DATES	
STREET ADDRESS 17 Outer Loop Drive			FIRST VISIT Jan. 2001	
CITY Chicago	STATE IL	ZIP 60686	LAST SEEN Oct. 13, 2003	
PHONE 312 555-9999	CHART/HMO #		NEXT APPOINTMENT Feb. 15, 2004	
REASONS FOR VISITS Liver problems. Dr. Simmons said I have cirrhosis. He also said my blurry vision was due to cataracts, but I don't have the money to have them removed.				
WHAT TREATMENT WAS RECEIVED? Dr. Simmons said the most important thing was for me not to drink any alcohol.				

If you need more space, use Remarks, Section 9.

E. List each HOSPITAL/CLINIC. Include your next appointment.

1. HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME Midwest Hospital			☒ INPATIENT STAYS (Stayed at least overnight)	DATE IN	DATE OUT
STREET ADDRESS 12001 Oakview				Jan. 15, 2003	Jan. 30, 2003
CITY Chicago	STATE IL	ZIP unknown	☐ OUTPATIENT VISITS (Sent home same day)	DATE FIRST VISIT	DATE LAST VISIT
PHONE 312 555-8888					
			☐ EMERGENCY ROOM VISITS	DATE OF VISITS	

Next appointment none Your hospital/clinic number don't know

Reasons for visits Put in hospital by Dr. Simmons to check my liver.

What treatment did you receive? Rest. Drained fluid from abdomen. Antibiotics and other drugs.

What doctors do you see at this hospital/clinic on a regular basis? Dr. Simmons called in a liver specialist in the hospital, but I don't remember her name.

Form SSA-3368-BK, Disability Report—Adult (Page 6)

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP			
PHONE			☐ OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT	DATE LAST VISIT
			☐ EMERGENCY ROOM VISITS	DATE OF VISITS	
Area Code Phone Number					

Next appointment _____ Your hospital/clinic number _____

Reasons for visits _____

What treatment did you receive? _____

What doctors do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9.

F. Does anyone else have medical records or information about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES (If "YES," complete information below.)

☒ NO

NAME	DATES
ADDRESS	FIRST VISIT
	LAST SEEN
PHONE	NEXT APPOINTMENT
Area Code Phone Number	
CLAIM NUMBER (If any) _____	
REASONS FOR VISITS _____	

If you need more space, use Remarks, Section 9.

Form SSA-3368-BK, Disability Report—Adult (Page 7)

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? ☒ YES
 If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)* ☐ NO

NAME OF MEDICINE	PRESCRIBED BY (Name of Doctor)	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE
Aldactone	Dr. Simmons	excess fluid in abdomen	weak
Xanax	Dr. Hill	nervousness	sleepy, lethargic

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for illnesses, injuries or conditions?
☒ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)	Jan. 2003	Midwest Hosp.	Dr. Simmons
TREADMILL (EXERCISE TEST)	None		
CARDIAC CATHETERIZATION	None		
BIOPSY--Name of body part	None		
HEARING TEST	None		
VISION TEST	None		
IQ TESTING	None		
EEG (BRAIN WAVE TEST)	None		
HIV TEST	None		
BLOOD TEST (NOT HIV)	Jan. 2003	Midwest Hosp.	Dr. Simmons
BREATHING TEST	None		
X-RAY--Name of body part <u>Chest, back, shoulder</u>	Jan. 2003 May 2003	Chest X-ray in Midwest Hosp. → Back & shoulder, Office of →	Dr. Simmons Dr. Bates
MRI/CT SCAN Name of body part <u>Abdomen</u>	Jan. 2003	Midwest Hosp.	Dr. Simmons

If you have had other tests, list them in Remarks, Section 9.

Form SSA-3368-BK, Disability Report—Adult (Page 8)

SECTION 7-EDUCATION/TRAINING INFORMATION

A. Check the highest grade of **school** completed.

Grade school:

0 1 2 3 4 5 6 7 8 9 10 11 12 GED
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☒

College:

1 2 3 4 or more
☐ ☐ ☐ ☐

Approximate **date** completed: 1967

B. Did you attend **special education** classes? ☐ YES ☒ NO (If "NO," go to part C)

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

City

State

Zip

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of **special job training, trade or vocational school**?

☐ YES ☒ NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 - VOCATIONAL REHABILITATION INFORMATION

A. Have you received services from **Vocational Rehabilitation** or any other organization to help you get back to work? ☐ YES ☒ NO (If "NO," go to part B)

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

City

State

Zip

DAYTIME PHONE NUMBER _____

Area Code

Number

DATES SEEN _____

TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____

(IQ, vision, physicals, hearing, workshops, etc.)

B. Would you like to receive rehabilitation services that could help you get back to work?

☒ YES ☐ NO

Form SSA-3368-BK, Disability Report—Adult (Page 9)

SECTION 9 - REMARKS

Use this section for any added information you did not show in earlier parts of the form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

Although Dr. Bates originally gave me pain medicine for my back and shoulder it had to be stopped, because it worsened my liver problem. So I have little relief of my back and shoulder pain. I can't bend over because of fluid in my abdomen and back pain. Lifting over 10 lbs. hurts my back and shoulder, and I can't reach overhead with my right arm anymore. I feel weak all the time, and cannot do much even around the house; mostly, I sit in a chair and read or watch TV. I try to help with some of the housework, but get tired in a few minutes. My wife now takes care of the car and all of the shopping. Sometimes, my daughter comes over and helps.

All of our savings are about gone. I lost my health insurance when I could no longer work, so my wife lost hers too. I can't afford to get treatment for my cataracts, and my vision is getting worse.

My psychiatrist, Dr. Hill, says that my nervousness will improve if my financial situation gets better. I'd like to learn some other type of work, if I can get help for my medical problems. But I just can't do the heavy work I did before.

Form SSA-3368-BK, Disability Report—Adult (Page 10)

SECTION 9 - REMARKS

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of **claimant** or person filing on claimant's behalf (*parent, guardian*) **Date** (*Month, day, year*)

William Hamilton

11-1-2003

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of **Witness**

2. Signature of **Witness**

Address (*Number and street, city, state, and ZIP code*)

Address (*Number and street, city, state, and ZIP code*)

Form SSA-16-F6, Application for Disability Insurance Benefits (Page 1)

SOCIAL SECURITY ADMINISTRATION		☐ TEL	Form Approved OMB No. 0980-0060	TOE 120/145
APPLICATION FOR DISABILITY INSURANCE BENEFITS I apply for a period of disability and/or all insurance benefits for which I am eligible under title II and part A of title XVIII of the Social Security Act, as presently amended.			(Do not write in this space)	

PART I - INFORMATION ABOUT THE DISABLED WORKER				
1.	(a) PRINT your name _____	FIRST NAME, MIDDLE INITIAL, LAST NAME John D. Doe		
	(b) Enter your name at birth if different from item (a) _____			
	(c) Check (X) whether you are _____	☒ Male ☐ Female		
2.	Enter your Social Security Number _____	1 2 3 / 4 5 / 6 7 8 9		
3.	(a) Enter your date of birth _____	MONTH, DAY, YEAR 6-12-49		
	(b) Enter name of State or foreign country where you were born. _____	California		
If you have already presented, or if you are now presenting, a public or religious record of your birth established before you were age 5, go on to item 4.				
	(c) Was a public record of your birth made before you were age 5?	☐ Yes ☐ No ☐ Unknown		
	(d) Was a religious record of your birth made before you were age 5?	☐ Yes ☐ No ☐ Unknown		
4.	(a) What are the illnesses, injuries, or conditions that limit your ability to work? (Give a brief description.) I have arthritis in my hands. I can't see very well, have trouble hearing, and my doctor says I have heart trouble.			
	(b) Are your illnesses, injuries, or conditions related to your work in any way? _____	☒ Yes ☐ No		
5.	(a) When did you become unable to work because of your illnesses, injuries or conditions? _____	MONTH, DAY, YEAR 5-23-2003		
	(b) Are you still unable to work? _____	☒ Yes ☐ No		
	(c) If you are no longer unable to work because of your illnesses, injuries or conditions, enter the date you became able to work. _____	MONTH, DAY, YEAR		
6.	(a) Have you (or has someone on your behalf) ever filed an application for Social Security benefits, a period of disability under Social Security, supplemental security income, or hospital or medical insurance under Medicare? _____		☐ Yes ☒ No ☐ Unknown (If "Yes," answer (b) and (c).) (If "No," or "Unknown," go on to item 7.)	
	(b) Enter name of person on whose Social Security record you filed other application. _____			
	(c) Enter Social Security Number of person named in (b). If unknown, check this block. ☐ _____	_ _ _ _ / _ _ / _ _ _ _		
7.	(a) Were you in the active military or naval service (including Reserve or National Guard active duty or active duty for training) after September 7, 1939 and before 1968? _____		☒ Yes ☐ No (If "Yes," answer (b) and (c).) (If "No," go on to item 8.)	
	(b) Enter dates of service _____	FROM: (Month, year) June 1964	TO: (Month, year) June 1967	
	(c) Have you <u>ever</u> been (or will you be) eligible for a monthly benefit from a military or civilian Federal agency? (include Veterans Administration benefits <u>only</u> if you waived military retirement pay) _____		☒ Yes ☐ No	

Form SSA-16-F6 (9-1999) EF (4-2000) Page 1
 Destroy prior editions

Form SSA-16-F6, Application for Disability Insurance Benefits (Page 2)

8.	(a) Have you filed (or do you intend to file) for any other public disability benefits? (Include workers' compensation and Black Lung benefits) _____	☒ Yes (If "Yes," answer (b).)	☐ No (If "No," go on to item 9.)
	(b) The other public disability benefit(s) you have filed (or intend to file) for is (Check as many as apply): ☒ Veterans Administration Benefits ☐ Supplemental Security Income ☐ Welfare ☐ Other (If "Other," complete a Workers' Compensation/Public Disability Benefit Questionnaire)		
9.	(a) Do you have social security credits (for example, based on work or residence) under another country's Social Security System? (If "Yes," answer (b).) (If "No," go on to item 10.) _____	☐ Yes	☒ No
	(b) List the country(ies): _____		
10.	(a) Are you entitled to, or do you expect to become entitled to, a pension or annuity based on your work after 1956 not covered by Social Security?	☐ Yes (If "Yes," answer (b) and (c).)	☒ No (If "No," go on to item 11.)
	(b) ☐ I became entitled, or expect to become entitled, beginning	MONTH	YEAR
	(c) ☐ I became eligible, or expect to become eligible, beginning	MONTH	YEAR
I agree to notify the Social Security Administration if I become entitled to a pension or annuity based on my employment after 1956 not covered by Social Security, or if such pension of annuity stops.			
11.	(a) Did you have wages or self-employment income covered under Social Security in all years from 1978 through last year?	☐ Yes (If "Yes," skip to item 12.)	☒ No (If "No," answer (b).)
	(b) List the years from 1978 through last year in which you did not have wages or self-employment income covered under Social Security.		
	1971, 1987		
12.	Enter below the names and addresses of all the persons, companies, or Government agencies for whom you have worked this year and last year. IF NONE, WRITE "NONE" BELOW AND GO ON TO ITEM 14.		
	NAME AND ADDRESS OF EMPLOYER (If you had more than one employer, please list them in order beginning with your last (most recent) employer)	Work Began	Work Ended (If still working show "Not Ended")
		MONTH	YEAR
	Bay Area Shipping Containers 12310 Front Street, San Francisco, CA	August	1972
	Acme Security Services 1984 Ashley Avenue, San Francisco, CA	January	1988
	Jewel's Food Services, 400 W. 19th St., Los Angeles, CA (If you need more space, use "Remarks" space on page 4.)	Feb.	1994
		July	1986
		Nov.	1993
		Aug.	2003
13.	May the Social Security Administration or the State agency reviewing your case ask your employers for information needed to process your claim? _____		
	☒ Yes ☐ No		
14.	THIS ITEM MUST BE COMPLETED, EVEN IF YOU WERE AN EMPLOYEE.		
	(a) Were you self-employed this year and last year? (If "Yes," answer (b).) (If "No," go on to item 15.) _____		
	☐ Yes ☒ No		
	(b) Check the year or years in which you were self-employed	In what kind of trade or business were you self-employed? (For example, storekeeper, farmer, physician)	Were your net earnings from your trade or business \$400 or more? (Check "Yes" or "No")
	☐ This year		
	☐ Last year	☐ Yes	☐ No
	☐ Year before last	☐ Yes	☐ No
15.	(a) How much were your total earnings last year? (Count both wages and self-employment income. If none, write "None.") _____		
	Amount \$ <u>23,990</u>		
	(b) How much have you earned so far this year? (If none, write "None.") _____		
	Amount \$ <u>12,130</u>		

Form SSA-16-F6, Application for Disability Insurance Benefits (Page 3)

(c) Did you receive any money from an employer(s) on or after the date in item 5(a) when you became unable to work because of your illnesses, injuries, or conditions? (If "Yes", give the amounts and explain in "Remarks" on page 4.)	☐ Yes ☒ No Amount \$ _____
(d) Do you expect to receive any additional money from an employer such as sick pay, vacation pay, other special pay? (If "Yes," please give amounts and explain in "Remarks" on page 4.)	☒ Yes ☐ No Amount \$ <u>1,200</u>

PART II — INFORMATION ABOUT THE DISABLED WORKER AND SPOUSE

16. Have you ever been married? (If "Yes," answer item 17.) (If "No," go on to item 18.)	☒ Yes ☐ No
17. (a) Give the following information about your current marriage. If not currently married, show your last marriage below.	
To whom married <u>Jane J. Doe</u>	When (Month, day, year) <u>April 5, 1975</u>
Where (Name of City and State) <u>Los Angeles, CA</u>	
Your current or last marriage	How marriage ended (If still in effect, write "Not Ended.")
	When (Month, day, year)
	Where (Name of City and State)
	Marriage performed by: ☒ Clergyman or public official ☐ Other (Explain in Remarks)
Spouse's date of birth (or age) <u>DOB 9-5-52</u>	
If spouse deceased, give date of death	
Spouse's Social Security Number (If none or unknown, so indicate) <u>1 2 3 / 4 5 / 6 7 8 9</u>	
(b) Give the following information about each of your previous marriages. (If none, write "NONE.")	
To whom married	When (Month, day, year)
Where (Name of City and State)	
Your previous marriage	How marriage ended
	When (Month, day, year)
	Where (Name of City and State)
	Marriage performed by: ☐ Clergyman or public official ☐ Other (Explain in Remarks)
Spouse's date of birth (or age)	
If spouse deceased, give date of death	
Spouse's Social Security Number (If none or unknown, so indicate) <u> / / </u>	

(Use a separate statement for information about any other marriages.)

18. Have you or your spouse worked in the railroad industry for 7 years or more?	☐ Yes ☒ No
--	---

PART III — INFORMATION ABOUT THE DEPENDENTS OF THE DISABLED WORKER

19. If your claim for disability benefits is approved, your children (including natural children, adopted children, and stepchildren) or dependent grandchildren (including stepgrandchildren) may be eligible for benefits based on your earnings record.	
List below: FULL NAME OF ALL such children who are now or were in the past 12 months UNMARRIED and: • UNDER AGE 18 • AGE 18 TO 19 AND ATTENDING SECONDARY SCHOOL • DISABLED OR HANDICAPPED (age 18 or over and disability began before age 22) (IF THERE ARE NO SUCH CHILDREN, WRITE "NONE" BELOW AND GO ON TO ITEM 20.)	
<u>Jonathan, age 32, mentally retarded and lives at home</u>	
20. Do you have a dependent parent who was receiving at least one-half support from you when you became unable to work because of your disability? (If "Yes," enter name and address in "Remarks" on page 4.)	☒ Yes ☐ No

Form SSA-16-F6, Application for Disability Insurance Benefits (Page 4)

**IMPORTANT INFORMATION ABOUT DISABILITY INSURANCE BENEFITS —
PLEASE READ CAREFULLY**

I. SUBMITTING MEDICAL EVIDENCE: I understand that as a claimant for disability benefits, I am responsible for providing medical evidence showing the nature and extent of my disability. I may be asked either to submit the evidence myself or to assist the Social Security Administration in obtaining the evidence. If such evidence is not sufficient to arrive at a determination, I may be requested by the State Disability Determination Service to have an independent examination at the expense of the Social Security Administration.

II. RELEASE OF INFORMATION: I authorize any physician, hospital, agency or other organization to disclose to the Social Security Administration, or to the State Agency that may review my claim or continuing disability, any medical record or other information about my disability. I also authorize the Social Security Administration to release medical information from my records, only as necessary to process my claim, as follows:

- Copies of medical information may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
- Results of any such independent examination may be provided to my personal physician.
- Information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service.
- The State Vocational Rehabilitation Agency may review any evidence necessary for determining my eligibility for rehabilitative services.

**THIS MUST
BE
ANSWERED** ➔

21. DO YOU UNDERSTAND AND AGREE WITH THE AUTHORIZATIONS GIVEN ABOVE?
☒ Yes ☐ No (If "No," explain why in "Remarks.")

22. Check if applicable:

- ☐ I am not submitting evidence of ☐ my ☐ the deceased's earnings that are not yet on ☐ my ☐ his/her earnings record. I understand that these earnings will be included automatically within 24 months, and any increase in benefits will be paid with full retroactivity.

REMARKS (You may use this space for any explanation. If you need more space, attach a separate sheet.)

\$1,200 sick pay from employer. My 85 year old mother lives with us and I pay most of her support

III. REPORTING RESPONSIBILITIES: I agree to promptly notify Social Security if:

- My **MEDICAL CONDITION IMPROVES** so that I would be able to work, even though I have not yet returned to work.
- I **GO TO WORK** whether as an employee or a self-employed person.
- I apply for or begin to receive a workers' compensation (including black lung benefits) or another public disability benefit, or the amount that I am receiving changes or stops, or I receive a lump-sum settlement.
- I am confined to jail, prison, a penal institution or correctional facility for conviction or a crime or I am confined to a public institution by court order in connection with a crime.

The above events may affect my eligibility or disability benefits as provided in the Social Security Act, as amended.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

SIGNATURE OF APPLICANT

Signature (First name, middle initial, last name) (Write in ink)

**SIGN
HERE** ➔

John O. Doe

Date (Month, day, year)

9-12-2003

Telephone Number(s) at which you may be contacted during the day. (Include the area code)

310-555-1111

**FOR
OFFICIAL
USE ONLY**

Direct Deposit Payment Address (Financial Institution)

Routing Transit Number

C/S

Depositor Account Number

☐ No Account

☐ Direct Deposit Refused

Applicant's Mailing Address (Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)

P.O. Box 24830

City and State

Los Angeles, CA

ZIP Code

90025

County (if any) in which you now live

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in Signature block.

1. Signature of Witness

2. Signature of Witness

Address (Number and street, City, State and ZIP Code)

Address (Number and street, City, State and ZIP Code)

Form SSA-16-F6, Application for Disability Insurance Benefits (Page 5)

FOR YOUR INFORMATION

An agency in your State that works with us in administering the Social Security disability program is responsible for making the disability decision on your claim. In some cases, it is necessary for them to get additional information about your condition or to arrange for you to have a medical examination at Government expense.

Collection and Use of Information From Your Application — Privacy Act Notice/Paperwork Act Notice

The Social Security Administration is authorized to collect the information on this form under sections 202(b), 202(c), 205(a), and 1872 of the Social Security Act, as amended (42 U.S.C. 402(b), 402(c), 405(a), and 1395(ii)). While it is VOLUNTARY, except in the circumstances explained below, for you to furnish the information on this form to Social Security, no benefits may be paid unless an application has been received by a Social Security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act. The information on this form is needed to enable Social Security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage.

Although the information you furnish on this form is almost never used for any other purpose than stated in the foregoing, there is a possibility that for the administration of the Social Security programs or for the administration of programs requiring coordination with the Social Security Administration, information may be disclosed to another person or to another governmental agency as follows: 1. to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; 2. to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Veterans Administration); and 3. to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT NOTICE AND TIME IT TAKES STATEMENT:

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 20 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

Form SSA-16-F6, Application for Disability Insurance Benefits (Page 6)

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

PERSON TO CONTACT ABOUT YOUR CLAIM

SSA OFFICE

DATE CLAIM RECEIVED

TELEPHONE NUMBER (INCLUDE AREA CODE)

Your application for Social Security disability benefits has been received and will be processed as quickly as possible.

some other change that may affect your claim, you — or someone for you — should report the change. The changes to be reported are listed below.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

Always give us your claim number when writing or telephoning about your claim.

In the meantime, if you change your address, or if there is

If you have any questions about your claim, we will be glad to help you.

CLAIMANT

SOCIAL SECURITY CLAIM NUMBER

CHANGES TO BE REPORTED AND HOW TO REPORT

FAILURE TO REPORT MAY RESULT IN OVERPAYMENTS THAT MUST BE REPAYED

- ▶ You change your mailing address for checks or residence. To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.
- ▶ You go outside the U.S.A. for 30 consecutive days or longer.
- ▶ Any beneficiary dies or becomes unable to handle benefits.
- ▶ Custody Change—Report if a person for whom you are filing or who is in your care dies, leaves your care or custody, or changes address.
- ▶ You are confined to jail, prison, penal institution or correctional facility for conviction of a crime or you are confined to a public institution by court order in connection with a crime.
- ▶ You become entitled to a pension or annuity based on your employment after 1956 not covered by Social Security, or if such pension or annuity stops.
- ▶ Your stepchild is entitled to benefits on your record and you and the stepchild's parent divorce. Stepchild benefits are not payable beginning with the month after the month the divorce becomes final.

- ▶ Change of Marital Status—Marriage, divorce, annulment of marriage.
- ▶ You return to work (as an employee or self-employed) regardless of amount of earnings.
- ▶ Your condition improves.
- ▶ If you apply for or begin to receive workers' compensation (including black lung benefits) or another public disability benefit, or the amount of your present workers' compensation or public disability benefit changes or stops, or you receive a lump-sum settlement.

HOW TO REPORT

You can make your reports by telephone, mail, or in person, whichever you prefer.

If you are awarded benefits, and one or more of the above changes occur, the change(s) should be reported by calling:

(Telephone Number—Include Area Code)

Form SSA-8000-BK, Application for Supplemental Security Income (Page 1)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration☐ TELForm Approved
OMB No. 0960-0229

APPLICATION FOR SUPPLEMENTAL SECURITY INCOME

Do not write in this space

I am/We are applying for Supplemental Security Income and any federally administered State supplementation under title XVI of the Social Security Act, for benefits under the other programs administered by the Social Security Administration, and where applicable, for medical assistance under title XIX of the Social Security Act.

☐ FS-SSA/APP ☐ FS-REFERRED

Filing Date

Month, Day, Year

☐ Actual or ☐ ProtectiveTYPE OF CLAIM ☐ Individual with Ineligible Spouse ☐ Couple ☐ Individual ☐ Child ☐ Child with Parent(s)**PART I—BASIC ELIGIBILITY**—The questions in this section pertain to the period beginning with the first moment of the filing date month through the date this application is signed unless a question specifies a different time period.

1.	(a) First Name, Middle Initial, Last Name Sherry L. Clark	Birth (month, day, year) 7-15-64	Sex ☐ Male ☒ Female	Social Security Number 2 3 4 / 5 6 / 7 8 9 0
	(b) Did you ever use any other names (including maiden name) or other Social Security numbers? →		☐ YES Go to (c) ☒ NO Go to #2	
	(c) Other Names and Social Security Numbers Used			
2.	(a) Are you married? →		☒ YES Go to (b) ☐ NO Go to #4	
	(b) Spouse's Name (First, middle initial, last) Paul A. Clark	Birth (month, day, year) 4-31-61	Social Security Number 2 3 4 / 5 6 / 7 8 9 1	
	(c) Did your spouse ever use any other names (including maiden name) or other Social Security Numbers? →		☐ YES Go to (d) ☒ NO Go to (e)	
	(d) Other Names (including maiden name) and Social Security Numbers Used by Spouse			
	(e) Are you and your spouse living together? →		☒ YES If your spouse is not filing go to #3; otherwise go to #4. ☐ NO Go to (f)	
	(f) Date you began living apart	Address of spouse or name and address of someone who knows where the spouse is.		
	(g) IF YOUR SPOUSE IS NOT FILING FOR SUPPLEMENTAL SECURITY INCOME AND YOU SEPARATED SINCE THE FIRST MOMENT OF THE FILING DATE MONTH GO TO #3. IF YOUR SPOUSE IS FILING FOR SUPPLEMENTAL SECURITY INCOME, GO TO #4.			
3.	(a) Is your spouse the sponsor of an alien for supplemental security income? →		☐ YES Go to (b) ☒ NO Go to #4	
	(b) Alien's Name		Alien's Social Security Number ____ / ____ / ____	

Form SSA-8000-BK, Application for Supplemental Security Income (Page 2)

4.	(a) Have you been married before? —————→		You ☒ YES ☐ NO Go to (b) Go to #5		Your Spouse, if filing ☐ YES ☐ NO Go to (b) Go to #5	
(b) Give the following information about your former spouse. If there was more than one former marriage, show the remaining information in Remarks and go to #5.						
		FORMER SPOUSE'S NAME (including maiden name)	SOCIAL SECURITY NUMBER (if none or unknown, so indicate)	DATE OF MARRIAGE	DATE MARRIAGE ENDED	HOW MARRIAGE ENDED
You		Mike Glenn	unknown	12-20-87	3-18-89	Divorce
Your Spouse						
5.	(a) Are you blind or disabled? —————→		You ☒ YES ☐ NO Go to (b) Go to #6		Your Spouse ☐ YES ☐ NO Go to (b) Go to #6	
(b) GIVE THE FOLLOWING INFORMATION:		DATE IMPAIRMENT BEGAN	NATURE OF THE IMPAIRMENT			
You		1995	arthritis, high blood pressure, nervous			
Your Spouse		NA				
6.	In what city and State or foreign country were you born? —————→		You Los Angeles, CA		Your Spouse, if filing	
7.	Are you a United States citizen by birth? —————→		☒ YES ☐ NO Go to #11 Go to #8		☐ YES ☐ NO Go to #11 Go to #8	
8.	Are you a naturalized United States citizen? —————→		☐ YES ☐ NO Go to #11 Go to #9		☐ YES ☐ NO Go to #11 Go to #9	
9.	(a) Are you lawfully admitted for permanent residence in the United States? —————→		☐ YES ☐ NO Go to (b) Go to #10		☐ YES ☐ NO Go to (b) Go to #10	
(b) Give the month, day, and year of lawful admission for permanent residence. If date is within 3 years of the filing date, go to (c); otherwise go to #11. —————→		DATE		DATE		
(c) Was your entry into the United States sponsored by any person or promoted by an institution or group? —————→		☐ YES ☐ NO Go to (d) Go to #11		☐ YES ☐ NO Go to (d) Go to #11		
(d) Give the following information about the person, institution, or group:						
Name		Address			Telephone No. (Include Area Code) () -	
(e) GO TO #11						
10.	(a) Is the Immigration and Naturalization Service (INS) aware of your presence in the United States? —————→		☐ YES ☐ NO Go to (b) Go to #11		Your Spouse, if filing ☐ YES ☐ NO Go to (b) Go to #11	
(b) Through what date will INS allow you to remain in the United States? (If indefinitely, so indicate) —————→		DATE (month, day, year)		DATE (month, day, year)		
11.	(a) When did you first make your home in the United States? —————→		DATE (month, day, year) 7-15-64		DATE (month, day, year)	
(b) Have you lived outside the United States since then? —————→		☐ YES ☒ NO Go to (c) Go to #12		☐ YES ☐ NO Go to (c) Go to #12		
(c) Give dates of residence outside the United States. (Month, day, year) —————→		FROM: TO:		FROM: TO:		
12.	(a) Have you been outside the United States (the 50 states, District of Columbia and Northern Mariana Islands) 30 days prior to the filing date? —————→		☐ YES ☒ NO Go to (b) Go to #13		☐ YES ☐ NO Go to (b) Go to #13	
(b) Give the date (Month, day, year) you left the United States and the date you returned to the United States. —————→		Date Left		Date Left		
		Date Returned		Date Returned		

Form SSA-8000-BK, Application for Supplemental Security Income (Page 3)

PART II—LIVING ARRANGEMENTS—The questions in this section pertain to the signature date.

13. Check the applicable block to show where you live now:

☐ House	☐ Room (commercial establishment)	☐ Transient	☐ School	☐ Rehabilitation Center
☒ Apartment	☐ Other (Specify) _____	☐ Hospital	☐ Jail	☐ Other (Specify) _____
☐ Room (private home)	☐ Mobile Home	☐ Rest or Retirement Home	☐ Nursing Home	
☐ Foster Home				

IF YOU ARE LIVING IN A FOSTER HOME, AN INSTITUTION, OR ARE A TRANSIENT, EXPLAIN IN REMARKS AND GO TO #21.

14. Do you live alone or with your spouse only? ☒ YES Go to #16 ☐ NO Go to #15

15. (a) Give the following information about everyone who lives with you (or with you and your spouse):

NAME	RELATIONSHIP TO YOU OR SPOUSE	SEX		DATE OF BIRTH (Month, day, year)	BLIND OR DISABLED		IF UNDER AGE 22			
		M	F		YES	NO	MARRIED		STUDENT	
							YES	NO	YES	NO

(b) Do all the persons listed in 15(a) receive assistance or income based on need? ☐ YES Go to (c) ☐ NO Go to (c)

(c) Does anyone listed in 15(a) who is not married and under age 18 OR between ages 18-21, not married, and a student receive income? ☐ YES Go to (d) ☐ NO Go to #16

CHILD RECEIVING INCOME	SOURCE & TYPE	MONTHLY AMOUNT
		\$
		\$
		\$

16. (a) Do you (or does anyone who lives with you) own or rent the place where you live? ☐ YES Go to #17 ☒ NO Go to (b)

(b) Name and address of person who owns or rents the place where you live:
Donald Kemp
114 Temple Street, Los Angeles, CA

Telephone number, if known
(Include Area Code)
(310) - 555-4444

(c) GO TO #20

17. (a) Are you (or your living with spouse) buying or do you own the place where you live? ☐ YES Go to (c) ☐ NO If you are a child living with parent(s) go to (b); otherwise go to #18.

(b) Are your parent(s) buying or do they own the place where you live? ☐ YES Go to (c) ☐ NO Go to #18

(c) What is the amount and frequency of the mortgage payment? Amount \$ Frequency of Payment

(d) GO TO #20

Form SSA-8000-BK, Application for Supplemental Security Income (Page 4)

18.	(a) Do you (or your living with spouse) have rental liability for the place where you live? →	☒ YES Go to (d)	☐ NO If you are a child living with parent(s) go to (b); otherwise go to (c).		
	(b) Do your parent(s) have rental liability? →	☐ YES Go to (d)	☐ NO Go to (c)		
	(c) Does anyone who lives with you have rental liability for the place where you live? →	☐ YES Give name of person with rental liability in Remarks and go to #19	☐ NO Give name of person with home ownership in Remarks and go to #20.		
	(d) What is the amount and frequency of the rent payment? →	Amount \$ 560	Frequency of payment monthly		
19.	(a) Are you (or anyone who lives with you) the parent or child of the landlord or the landlord's spouse? →	☐ YES Go to (b)	☒ NO Go to #20		
	(b) Name of person related to landlord or landlord's spouse:	Relationship	Name and address of landlord (include telephone number and area code, if known):		
20.	(a) Does anyone who does NOT live with you provide your household with all or part of the food and shelter (including payment of the bills for food, rent or home mortgage payments, property insurance required by the mortgage holder, real property taxes, heating fuel, gas, electricity, garbage removal, water, or sewerage) or give the household money for these items? →				
	☒ YES Go to (b) ☐ NO Go to (c)				
	(b)	ITEM	CONTRIBUTOR'S NAME AND ADDRESS (TELEPHONE NUMBER AND AREA CODE, IF KNOWN)	MONTHLY AMOUNT	MONTHS RECEIVED
		food	John Ford, 112 W 15th, LA, CA	\$ 200	3
		electricity	Betty Clark (sister) Townhouse Apts. #110 LA, CA 310-555-2222	\$ 100	6
				\$	
				\$	
	(c) GO TO (d) IF YOU (OR YOUR LIVING WITH SPOUSE) OWN OR RENT AND LIVE WITH OTHERS (OTHER THAN SPOUSE ONLY) BUT YOU DO NOT LIVE IN A PUBLIC ASSISTANCE HOUSEHOLD; OTHERWISE, GO TO #21.				
	(d) Does anyone living with you give you (or your living with spouse) money for or help pay for all or part of your food, rent or home mortgage payments, property insurance required by the mortgage holder, real property taxes, heating fuel, gas, electricity, garbage removal, water, or sewer bills? →			☐ YES Go to #21 ☒ NO Go to #21	
21.	(a) Has the information given in items #13 through #20 been the same since the first moment of the filing date month? →			☒ YES Go to (b) ☐ NO Explain in Remarks and go to (b).	
	(b) Do you expect this information to change? →			☐ YES Explain in Remarks and go to #22. ☒ NO Go to #22	

PART III—RESOURCES—The questions in this section pertain to the first moment of the filing date month.

22.	(a) Do you own or does your name appear on the title of any vehicles; e.g., cars, trucks, boats, motorcycles, etc.? →	You ☒ YES Go to (b) ☐ NO Go to #23		Your Spouse ☐ YES Go to (b) ☒ NO Go to #23			
	(b)	OWNER'S NAME	DESCRIPTION (YEAR, MAKE & MODEL)	USED FOR	EQUIPPED FOR HANDICAPPED?	CURRENT MARKET VALUE	AMOUNT OWED
		Paul Clark	1972 Ford	personal	X	\$ 50	\$ 0
						\$	\$
						\$	\$

Form SSA-8000-BK, Application for Supplemental Security Income (Page 5)

23.	(a) Do you own or are you buying any life insurance policies? _____		You ☐ YES Go to (b)		☒ NO Go to #24		Your Spouse ☐ YES Go to (b)		☒ NO Go to #24		
	(b) Give the following information on each policy:										
OWNER'S NAME			NAME OF INSURED			NAME AND ADDRESS OF INSURANCE COMPANY					
Policy (#1)											
Policy (#2)											
Policy (#3)											
POLICY NUMBER			FACE VALUE	CASH SURRENDER VALUE	DATE PURCHASED	LOANS AGAINST					
						YES			NO		
Policy (#1)			\$	\$		\$					
Policy (#2)			\$	\$		\$					
Policy (#3)			\$	\$		\$					

24.	(a) Do you (either alone or jointly with any other person) own any:		You YES NO		Your Spouse YES NO	
	Life estates or ownership interest in an unprobated estate? →			X		X
Household or personal items worth more than \$500 each? →			X		X	
(b) Give the following information for any "Yes" answer in 24(a); otherwise go to #25						
OWNER'S NAME		NAME OF ITEM	VALUE	AMOUNT OWED ON ITEM	WHERE APPROPRIATE, GIVE NAME AND ADDRESS OF BANK OR OTHER ORGANIZATION	
			\$	\$		
			\$	\$		

25.	(a) Do you own or does your name appear (either alone or with any other person's name) on any of the following items?		You YES NO		Your Spouse YES NO	
	Cash at home, with you, or anywhere else →			X		X
Checking Accounts →			X		X	
Savings Accounts →			X		X	
Credit Union Accounts →			X		X	
Christmas Club Accounts →			X		X	
Certificates of Deposit →			X		X	
Notes →			X		X	
Stocks or Mutual Funds →			X		X	
Bonds →			X		X	
Other items that can be turned into cash →			X		X	
(b) Give the following information for any "Yes" answer in 25(a); otherwise go to #26						
OWNER'S NAME		NAME OF ITEM	VALUE	NAME AND ADDRESS OF BANK OR OTHER ORGANIZATION IF APPROPRIATE		IDENTIFYING NUMBER
			\$			
			\$			
			\$			
			\$			

Form SSA-8000-BK, Application for Supplemental Security Income (Page 6)

26.	(a) Do you have any land, houses, buildings, real property, property in foreign countries, equipment, business, mineral rights or other money or property of any kind (including belongings held in safe deposit boxes) that have not been shown elsewhere on the application? (Include assets set aside for an emergency or to provide for your heirs.) →	You ☐ YES Go to (b)	☒ NO Go to #27	Your Spouse ☐ YES Go to (b)	☒ NO Go to #27
(b) Give the following information:					
DESCRIPTION OF PROPERTY (If real property, include type and size of structure, acreage or lot size, location.)			HOW IS IT USED? (If not used now, when was it last used and what is next planned use.)		
Item 1			Item 1		
Item 2			Item 2		
OWNER'S NAME		ESTIMATED CURRENT MARKET VALUE	TAX ASSESSED VALUE	AMOUNT OF MORTGAGE PAYMENT	AMOUNT OWED ON ITEM
Item 1		\$	\$	\$	\$
Item 2		\$	\$	\$	\$

27.	(a) Have you sold, transferred title, disposed of or given away any money or other property, including property or money in foreign countries, since the first moment of the filing date month or within the 30 months prior to the filing date month?	You ☐ YES Go to (b)	☒ NO Go to #28	Your Spouse, if filing ☐ YES Go to (b)	☒ NO Go to #28
(b) Give the following information:					
OWNER'S NAME	DATE OF DISPOSAL	DESCRIPTION OF PROPERTY			
Item 1					
Item 2					
IF THE DATE OF DISPOSAL IS BEFORE 7/1/88 AND LESS THAN 24 MONTHS PRIOR TO THE MONTH OF FILING OR IF THE DATE OF DISPOSAL IS AFTER 6/30/88, GO TO 27(c); OTHERWISE GO TO #28.					
(c) Give the following about the information in 27(b):					
NAME AND ADDRESS OF PURCHASER OR RECIPIENT			RELATIONSHIP TO OWNER	SOLD ON OPEN MARKET	
Item 1				YES	NO
Item 2				YES	NO
VALUE OF PROPERTY AND/OR AMOUNT OF CASH GIFT	SALES PRICE OR OTHER AGREEMENT	ARE ADDITIONAL CONSIDERATIONS OR PROCEEDS EXPECTED? EXPLAIN		DO YOU STILL OWN PART OF THE PROPERTY	
Item 1				YES	NO
Item 2				YES	NO

Form SSA-8000-BK, Application for Supplemental Security Income (Page 7)

28.	(a) Have you acquired any resource since the first moment of the filing date month? →	You ☐ YES Go to (b)	☒ NO Go to (c)	Your Spouse ☐ YES Go to (b)	☒ NO Go to (c)
	(b) Explain any "Yes" answer given in 28(a)				
	You	Your Spouse			
	(c) Has there been any increase or decrease in the value of your resources since the first moment of the filing date month? →	You ☐ YES Go to (d)	☒ NO Go to #29	Your Spouse ☐ YES Go to (d)	☒ NO Go to #29
	(d) Explain any "Yes" answer given in 28(c)				
	You	Your Spouse			
29.	(a) Do you have any assets set aside for burial expenses such as burial contracts, trusts, agreements, or anything else you intend for your burial expenses? Include any assets mentioned in items #22 through #26 and item #28. →	You ☐ YES Go to (b)	☒ NO Go to #30	Your Spouse ☐ YES Go to (b)	☒ NO Go to #30
	(b) DESCRIPTION (Where appropriate, give name and address of organization and account/policy number)	VALUE	WHEN SET ASIDE (Month, Day, Year)	OWNER'S NAME	
	Item 1	\$			
	Item 2	\$			
	FOR WHOSE BURIAL	IS ITEM IRREVOCABLE?	WILL INTEREST EARNED OR APPRECIATION IN VALUE REMAIN IN THE BURIAL FUND?		
	Item 1	☐ YES ☐ NO	☐ YES Go to #30 ☐ NO Explain in (c)		
	Item 2	☐ YES ☐ NO	☐ YES Go to #30 ☐ NO Explain in (c)		
	(c) Explanation:				
	Item 1				
	Item 2				
30.	(a) Do you own any cemetery lots, crypts, caskets, vaults, urns, mausoleums or other repositories for burial or any headstones or markers? →	You ☐ YES Go to (b)	☒ NO Go to #31	Your Spouse ☐ YES Go to (b)	☒ NO Go to #31
	OWNER'S NAME	DESCRIPTION	FOR WHOSE BURIAL	RELATIONSHIP TO YOU OR SPOUSE	CURRENT MARKET VALUE (if applicable)
					\$
					\$

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PART IV—INCOME—The questions in this section specify time period.

31. (a) Since the first moment of the filing date month, have you received or do you expect to receive income in the next 14 months from any of the following sources?	YOU		YOUR SPOUSE	
	YES	NO	YES	NO
FEDERAL BENEFITS:				
Social Security		X		X
Railroad Retirement		X		X
Veterans Administration (Based on need/not based on need)		X		X
Office of Personnel Management (Civil Service)		X		X
Military Pension, Special Pay, or Allowance		X		X
Black Lung		X		X
Bureau of Indian Affairs		X		X
Earned Income Tax Credits		X		X
STATE/LOCAL BENEFITS:				
Unemployment Compensation		X		X
Workers' Compensation		X		X
State Disability		X		X
State or Local Pension		X		X
Aid to Families with Dependent Children		X		X
State or Local Assistance Based on Need		X		X
PRIVATE BENEFITS:				
Employer or Union Pension		X		X
Insurance or Annuity Payments		X		X
MISCELLANEOUS:				
Interest (bank accounts, stocks, CD's, etc.)		X		X
Rental/Lease Income		X		X
Dividends/Royalties		X		X
Alimony		X		X
Child Support		X		X
OTHER INCOME NOT PREVIOUSLY MENTIONED		X		X

(b) Give the following information for any "Yes" answer in 31(a); otherwise go to #32.

PERSON RECEIVING	TYPE OF INCOME	AMOUNT	FREQUENCY	DATES EXPECTED OR RECEIVED	SOURCE (Name/Address of Person, Bank, Company, or Organization)	IDENTIFYING NUMBER
You		\$		From: ----- To:		
You		\$		From: ----- To:		
You		\$		From: ----- To:		
Your Spouse		\$		From: ----- To:		
Your Spouse		\$		From: ----- To:		
Your Spouse		\$		From: ----- To:		

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32.	Since the first moment of the filing date month, have you received or do you expect to receive any clothing, meals, or other gifts which are not cash? →	You ☐ YES Explain in Remarks and go to #33	☒ NO Go to #33	Your Spouse ☐ YES Explain in Remarks and go to #33	☒ NO Go to #33	
33.	(a) Have you received wages since the first moment of the filing date month through the current month? →	☐ YES Go to (b)	☒ NO Go to (d)	☐ YES Go to (b)	☒ NO Go to (d)	
(b) Name and Address of Employer (include telephone number and area code, if known)						
You			Your Spouse			
(c) Total wages received (before any deductions) for each month:						
You	Month(s)					
	Amounts					
Your Spouse	Month(s)					
	Amounts					
(d) Do you expect to receive any wages in the next 14 months? →		☐ YES Go to (e)	☐ NO Go to #34	☐ YES Go to (e)	☐ NO Go to #34	
(e) Name and address of employer if different from 33(b) (include telephone number and area code, if known)						
You			Your Spouse			
(f) Give the following information:						
	RATE OF PAY	AMOUNT WORKED PER PAY PERIOD	HOW OFTEN PAID	PAY DAY OR DATE PAID	DATE LAST PAID (Month, day, year)	
You	\$ per					
Your Spouse	\$ per					
(g) Do you expect any change in wage information provided in 33(f)? →		☐ YES Go to (h)	☐ NO Go to #34	☐ YES Go to (h)	☐ NO Go to #34	
(h) Explain change:						
You			Your Spouse			
34.	(a) Have you been self-employed at any time since the beginning of the taxable year in which the filing date month occurs or do you expect to be self-employed in the current taxable year?	☐ YES Go to (b)	☒ NO Go to #35	☐ YES Go to (b)	☒ NO Go to #35	
(b) Give the following information:						
	TYPE OF BUSINESS	LAST YEAR'S:			THIS YEAR'S:	DATES OF SELF-EMPLOYMENT
		GROSS INCOME	NET INCOME LOSS		GROSS INCOME	NET INCOME LOSS
You		\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$
Your Spouse		\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$

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IF YOU OR YOUR SPOUSE ARE DISABLED AND RECEIVE WAGES OR EXPECT TO RECEIVE WAGES OR ARE SELF-EMPLOYED OR EXPECT TO BE SELF-EMPLOYED, ANSWER #35: OTHERWISE, GO TO #36.

35.	Do you have any special expenses related to your illness or injury that you paid which are necessary for you to work? →	You		Your Spouse	
		☐ YES Describe in Remarks and go to #36	☒ NO Go to #36	☐ YES Describe in Remarks and go to #36	☒ NO Go to #36

IF YOU ARE FILING AS A CHILD, AND YOU ARE EMPLOYED OR AGE 18-22 (WHETHER EMPLOYED OR NOT), GO TO #36; OTHERWISE, GO TO #37.

36.	(a) Have you attended school regularly since the filing date month? →	☐ YES Go to (d)	☐ NO Go to (b)
	(b) Have you been out of school for more than 4 calendar months? →	☐ YES Go to (c)	☐ NO Go to (c)
	(c) Do you plan to attend school regularly during the next 4 months? →	☐ YES Explain absence in Remarks and go to (d)	☐ NO Go to #37
	(d) Give the following information:		

NAME AND ADDRESS OF SCHOOL	NAME OF PERSON AT SCHOOL WE MAY CONTACT	DATES OF ATTENDANCE		COURSE OF STUDY
	NAME	FROM	TO	
	PHONE (include area code)	HOURS ATTENDING OR PLANNING TO ATTEND:		
	() -			

PART V—POTENTIAL ELIGIBILITY FOR OTHER BENEFITS/FOOD STAMPS/MEDICAL ASSISTANCE

37.	(a) Have you or a former spouse (or if you are filing as a child, have you or your parents) ever:	YOU		YOUR SPOUSE	
		YES	NO	YES	NO
	Worked for a railroad?		X		X
	Been in military service?		X		X
	Worked for the Federal government?		X		X
	Worked for a State or local government?		X		X
	Worked for an employer or belonged to a union with a pension plan?		X		X
	Done work that was covered under the Social Security system or pension plan of a country other than the United States?		X		X
(b) Explain and include dates (if appropriate) for any "Yes" answer given in 37(a); otherwise go to #38.					
YOU			YOUR SPOUSE		

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38.	(a) Are you currently receiving food stamps or has a food stamp application been filed for you within the past 60 days on which there has not been a decision? —————→	You ☐ YES Go to #39	☒ NO Go to (b)	Your Spouse, if filing ☐ YES Go to #39	☒ NO Go to (b)
	(b) Do you wish to apply for food stamps? —————→	☒ YES	☐ NO	☒ YES	☐ NO
39.	Where this application is an application for Title XIX under the Social Security Act, I/we understand that if I/we refuse to assign my/our rights to medical support and payments for medical care from any individual or private, group, or government health insurance, or refuse to cooperate in giving information regarding any health insurance I/we may have, that the Social Security Administration cannot determine whether I am/we are eligible for Medicaid and that I/we must then apply for Medicaid at the Medicaid agency. I/we also understand that as a condition to become eligible for Medicaid, I/we must cooperate with the Medicaid agency in establishing paternity and in obtaining medical support and payments from third party payers.				
IN STATES WITH AUTOMATIC ASSIGNMENT OF RIGHTS LAWS, GO TO 39(b).					
	(a) Do you agree to assign your rights (or the rights of anyone for whom you can legally assign rights) to payments for medical support and other medical care to the State Medicaid agency? —————→	You ☐ YES Go to (b)	☐ NO Go to #40	Your Spouse, if filing ☐ YES Go to (b)	☐ NO Go to #40
	(b) Do you, your spouse, parent or step-parent have any private, group, or government health insurance that pays the cost of your medical care? (Do not include Medicare or Medicaid) —————→	☐ YES	☐ NO	☐ YES	☐ NO
	(c) Do you have any unpaid medical expenses for the 3 months prior to the filing date month? —————→	☐ YES	☐ NO	☐ YES	☐ NO

PART VI—MISCELLANEOUS**ANSWER #40 ONLY IF YOU ARE REQUESTING BENEFITS ON BEHALF OF SOMEONE ELSE; OTHERWISE, GO TO #41.**

40.	(a) Name of Person Requesting Benefits	Relationship to Claimant	Your Social Security Number ____/____/____	
	(b) Do you wish to be selected as the claimant's representative payee? —————→	☐ YES	If you are applying on behalf of a child go to (c); otherwise go to #41.	☐ NO Explain in Remarks and go to #41.
	(c) Are you the natural or adoptive parent with custody? —————→	☐ YES	Go to (d)	☐ NO Go to (d)
	(d) Have you ever been convicted of a felony? —————→	☐ YES	Explain in Remarks and go to (e)	☐ NO Go to (e)
	(e) Are you serving, or have you ever served, as representative payee for anyone receiving a Social Security or Supplemental Security Income benefit? —————→	☐ YES	Enter SSN's in Remarks and go to (f)	☐ NO Go to (f)
	(f) Does the claimant have a legal representative or a legal guardian appointed by a court? —————→	☐ YES	If you are NOT the legal rep/guardian, go to (g); otherwise go to (h).	☐ NO Go to #41
(g) Give the following information about the legal representative or legal guardian:				
Name		Address		Telephone Number (Include area code, if known) (____) - _____
(h) Explain what led the court to appoint a legal representative or a legal guardian.				

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PART VII—REMARKS—(You may use this space for any explanations. Enter the item number before each explanation. If you need more space, use a signed form SSA-795.)

My husband and I have essentially no money or assets. We had been using my husband's savings to buy necessities and pay the rent, but that money is now all gone. We need money to live and I need help getting medical care.

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IMPORTANT INFORMATION—PLEASE READ CAREFULLY

- ▶ Failure to report any change within 10 days after the end of the month in which the change occurs could result in a penalty deduction.
- ▶ The Social Security Administration will check your statements and compare its records with records from other State and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount.
- ▶ If you are disabled or blind, you must accept any appropriate vocational rehabilitation services offered to you by the State agency to which we refer you.

PART VIII—SIGNATURES

I/We understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime which can be punished under Federal law, State law, or both. Everything on this application is the truth as best I/we know it.

41.	Your Signature (First name, middle initial, last name) (Write in ink)	Date (Month, day, year) <u>7-19-2003</u> Telephone number(s) at which you may be contacted during the day (<u>213</u>) - <u>555-6666</u> AREA CODE
	SIGN HERE Sherry L. Clark	
42.	Spouse's Signature (First name, middle initial, last name) (Write in ink) (Sign only if applying for payments.)	
	SIGN HERE	
43.	DIRECT DEPOSIT PAYMENT ADDRESS (FINANCIAL INSTITUTION)	
	FOR OFFICIAL USE ONLY Routing Transit Number C/S Depositor Account Number ☐ No Account ☐ Direct Deposit Refused	
44.	Applicant's Mailing Address (Number and Street, Apt. No., P.O. Box or Rural Route)	
	100 W. 95th Street City and State Los Angeles, CA ZIP Code 90055 Enter name of county (if any) in which you live LA	
45.	Claimant's Residence Address (If different from applicant's mailing address)	
	City and State ZIP Code Enter name of county (if any) in which the claimant lives	

WITNESSES

46.	Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing who know you must sign below giving their full addresses.	
	1. Signature of Witness	2. Signature of Witness
	Address (Number and Street, City, State, and ZIP Code)	Address (Number and Street, City, State, and ZIP Code)

1. What SSA Needs to Process Your Claim

The SSA needs several types of information to process your disability claim.

a. Social Security Number and Birth Certificate

The SSA needs your Social Security number and birth certificate or other proof of your age. You will also need to provide the Social Security numbers and birth certificates for family members—such as a disabled adult child—applying for benefits on your earnings record.

If you submit an original record of some kind, the SSA will return it to you after making a copy. If you cannot or do not want to submit an original record, you can offer a copy, if it is properly certified. You can obtain a properly certified copy from any of the following:

- the official custodian of the record
- an SSA employee authorized to certify copies, who can certify that the copy is an exact reproduction of an original
- a U.S. consular officer or employee of the State Department authorized to certify evidence received outside the United States, or
- an employee of a state agency or state welfare office authorized to certify copies of original records in the agency's or office's files.

There is one exception: You may give the SSA an uncertified photocopy of a birth registration notification where it is the practice of the local birth registrar to issue them in this way.

The SSA needs proof of your age, unless your eligibility for disability or your benefit amount does not depend on your age, as would be the case if you applied for SSI. The preferred evidence is a birth certificate or hospital birth record that was recorded before age five or a religious record (such as a baptism record) that shows your date of birth and was recorded before age five. If you cannot obtain any of these, you will be asked for other convincing evidence of your date of birth or age at a certain time. Possible evidence includes the following (20 CFR § 404.701-716):

- original family Bible or family record
- school records

- census records
- statement signed by a physician or midwife present at your birth
- insurance policies
- marriage record
- passport
- employment record
- delayed birth certificate, or
- immigration or naturalization record.

b. Medical Records

The SSA will need several kinds of medical records, including the following:

- information from your doctors, therapists, hospitals, clinics and caseworkers
- laboratory and test results
- names, addresses, phone numbers and fax numbers of your doctors, clinics and hospitals, and
- names of all medications you take.

You may not have your medical records when you first apply for benefits. If so, your medical providers will receive a request for that information from the agency that processes the medical portion of your application on behalf of the SSA. (See Section E, below.) Waiting for medical records is one of the biggest reasons for delays in the disability process. The more records you can turn over to the SSA with your application, the faster a decision on your claim is likely to be made. Also, if you claim that your disability began many years back, the SSA has to obtain those old medical records, and this can further delay your claim.

The SSA will never send your disability forms to your treating doctors. In fact, the SSA specifically requests that you not send your paperwork to your doctor. This is good advice, because your form might get lost or be delayed for months in a doctor's office. Your doctor is not responsible for completing your forms—you are, and your doctor probably would not appreciate receiving your paperwork to complete. The SSA will request specific medical information it wants directly from your doctors without your needing to do anything other than identify the doctors. If you want to get involved, call your doctor's office and

make sure your doctor responds to the SSA's request for information and sends in a complete and accurate report.



Ask your doctor to send you a copy of the report she sends the SSA. This is extremely important. If your doctor states that you are capable of doing things that you cannot do, you will need to get your doctor to send a corrected report.

c. Employment Information

You will need to indicate the names of your employers and your job duties for the last 15 years. If you can't remember, write "unknown" in the space where the information is required, but do not leave it blank. You will also be asked if your medical disorder affected your attendance at work or the hours you could work, and whether your employer had to give you special help in order for you to do your job. Adding this information helps you, as it might result in a finding that your disability started further back in time. In some instances, it might even be critical in determining whether you are disabled.

Specific information about your work history can be extremely important. You'll need to give your job title, type of business, dates worked, days per week and rate of pay. Again, if you can't remember, state that in the appropriate spaces. Do not leave parts of the form blank. Where you can remember, you'll be asked to describe your basic job duties, such as:

- the machines, tools and equipment you used and the operations performed
- the technical knowledge or skills involved in your work
- the type of writing you did and the nature of any reports, and
- the number of people you supervised and the extent of your supervision.

You will be asked to describe the kind and amount of physical activity you did at work, including walking, standing, sitting and bending. In addition, the SSA wants to know about the lifting and carrying you did on the job.

You don't have to answer all questions about your work at the time you apply for disability benefits, but the information will have to be given to the SSA at some time before a disability determination is made. If you omit any information, you'll hear from the SSA or the agency processing the medical portion of your application. If you don't understand a question, contact an SSA representative at the Field Office or the disability examiner who has been assigned your claim once it leaves the Field Office.

d. Activities of Daily Living

The claims representative or interviewer may give you forms asking detailed questions about your activities of daily living, called ADLs. The ADL form asks specific questions about what you do during a typical day to give the SSA an idea of how your impairment affects your daily life. ADLs are important in all kinds of disabilities, especially mental disorders. Questions typically deal with your ability to do household chores, cook, shop, visit friends, attend social activities and attend to finances.

If you don't answer the questions about your ADLs when you apply, the Disability Determination Services (DDS)—the state agency that receives your file from the Field Office to process your claim—will send you forms requesting the information. (The DDS is discussed in Section B5, below.) Some people just put "none" in answer to all questions about what they do during a typical day. These answers are considered uncooperative and will not help your claim, because everyone does something. Even sitting in a chair all day watching TV is an activity. Try to explain how your mental or physical impairments are related to what you can or cannot do during the day.

Don't rely on your doctor to answer these questions. Few doctors actually know what their patients do during the day. If you want your doctor to have this information, discuss your daily activities with your doctor. This will help with your credibility when officials contact your doctor, who can then verify the limitations you have reported.

e. School Records

If you are applying for disability for a child, you will need to provide school records regarding your child's disability. (This is explained in more detail in Chapter 3.)

f. Income and Asset Information

To receive SSI, your income and assets cannot exceed a certain limit. You will need records, such as bank statements, rent receipts and car registration to show what you earn and your financial worth.

In addition, the SSA will want a copy of your most recent W-2 form, if you are employed, or your tax return, if you're self-employed. All of this information is to help determine your income and assets.

2. Field Office Observations

If you don't apply over the phone, the Field Office representative will observe you while you complete your application form. He will note how you perform reading, writing, answering, hearing, sitting, understanding, using your hands, breathing, seeing, walking and anything else that might relate to your claim. You won't be given any medical tests at the Field Office, and the person who takes your application is not a doctor. But the representative will write down what he saw.

The SSA reviewers will pay attention to these observations, which don't determine the outcome of your claim, but are weighed with the other data. If the Field Office representative stated you had no difficulty walking while the medical information says you do, then the observation would be disregarded. But usually, Field Officers bring things to the attention of the evaluator that otherwise might be missed. For example, a Field Office representative can note if you need special assistance in completing your application because of apparent mental illness or limited English skills. A person who cannot speak English has fewer work opportunities, which can be important in the final decision on whether or not to award benefits.

3. Onset of Your Disability

On your disability application, you will have to state the date you became disabled. This is called the alleged onset date, or AOD. (See Chapter 10 for more on the onset date.)

If you are applying for SSDI, you set the date of your AOD. But the SSA will not allow benefits for any time when you were engaged in substantial gainful activity and earning too much money to qualify. The ultimate determination of your AOD is made by the SSA, and is influenced both by non-medical eligibility factors (see the next section) and the date the SSA considered you unable to do substantial gainful work.

If you're applying for SSI, your onset date does not matter. That is because SSI benefits are never awarded for earlier than the first day of the month after you file for disability.

4. Nonmedical Eligibility Requirements

To receive disability benefits, it is not enough to have a medical disorder preventing you from working. Other things that make you unable to work may also be considered. First it must be established that you are covered under SSDI or qualified to apply for SSI benefits because of low income and resources. Then you must also satisfy the *nonmedical* eligibility requirements before your medical disorder is even considered by the SSA. Determining whether or not you satisfy nonmedical requirements is the job of the Field Office. Nonmedical criteria include your age, employment, marital status, Social Security coverage information and other factors. Age, education and work experience are the most important. These are called *vocational factors* and are discussed in Chapter 9.

5. Processing Your Application (or Claim)

The agency that determines whether your medical disorder is severe enough to qualify you for benefits is known as a Disability Determination Service, or DDS. Your file is sent there once the SSA Field Office

determines that you meet the nonmedical eligibility requirements based on information in your application and your interview with the SSA representative. Several states with large populations have more than one DDS office, but most states have only one. (Your local SSA Field Office can give you the contact information for the DDS that will handle your claim.)

While Field Offices deal with all kinds of Social Security issues, the DDS is concerned only with determining your medical eligibility for disability benefits. The DDS employees and consultants are hired by the state, not by the SSA.



It is not the job of the SSA Field Office to make a medical determination about you. This is the responsibility of the DDS. If you meet the nonmedical eligibility requirements, the SSA Field Office *must* forward your application to the DDS. SSA representatives at Field Offices and contact stations are not doctors and should not give you an opinion regarding whether or not you are medically disabled.

Once the DDS receives your file, representatives there collect more information, especially medical information, and decide whether you are eligible for disability benefits. The DDS sends requests to your treating doctors and hospitals for your medical records, based on the information you provide. Nonmedical information, such as detailed data about your work activities or skills, may also be obtained by the DDS. If the DDS needs more information, the examiner will contact you by telephone or in writing. It is vital that the DDS be able to communicate with you to obtain full and accurate information and, in some cases, to request that you undergo medical examinations or laboratory tests at the expense of the SSA. (The DDS is discussed more fully in Chapter 6. Types of evidence the DDS might need are discussed in Chapter 5.)

C. Healthcare Professionals

Healthcare professionals play a vital role in the disability determination process and participate in the process in a variety of ways. These professionals include:

- treating sources, who provide medical evidence on behalf of their patients
- consultative examination sources, who perform necessary examinations or tests
- medical consultants, who review claims, and
- medical experts, who testify at administrative hearings.

1. Treating Sources

A treating source is the physician, psychologist or other acceptable medical source who has treated or evaluated you and has or had an ongoing treatment relationship with you. Your treating source is usually the best source of medical evidence about the nature and severity of your condition. If the DDS or SSA needs additional examinations or tests to process your claim, your treating source is usually the preferred person to perform the examination or test. (Acceptable medical sources are discussed in Chapter 5.)

The treating source is neither asked nor expected to decide if you are disabled. But the treating source will usually be asked to provide a statement about your ability to do work-related physical or mental activities, despite your condition.

2. Consultative Examination Sources

If your treating sources don't provide sufficient medical evidence, the DDS may request additional examinations or tests. These examinations or tests are performed by physicians, osteopaths, psychologists, or in certain circumstances, other health professionals. Other health professionals include people such as audiologists to test hearing, and speech therapists (also known as speech language pathologists) to evaluate speech. All consultative examiners must be currently licensed in your state and have the training and experience to perform the type of examination or test requested.

If you must undergo exams or tests by a consulting examination source, you will not have to pay a fee. If you are denied benefits and appeal, the SSA can ask the DDS to administer the tests or examinations if it

needs more information. The DDS is responsible for oversight of its consultative examination program.

Medical professionals who serve as consultative examiners must have a good understanding of the SSA's disability programs and the type of evidence required to make a disability determination. In addition, these medical professionals are made fully aware by the DDS of their responsibilities and obligations regarding confidentiality, as well as the administrative requirements for scheduling examinations and tests and issuing a report.

3. Medical Consultants

The consultants who review claims for disability benefits on behalf of the DDS or SSA include licensed medical doctors of virtually all specialties, osteopaths and psychologists with a Ph.D. The work is performed in a DDS office, an SSA regional office or the SSA's central office. It is strictly a paper review; the consultant usually has no contact with you. (Medical consultants are discussed in more detail in Chapter 6.)

4. Medical Experts

If you are denied benefits and appeal, an administrative law judge (ALJ) in the Office of Hearings and Appeals will hear your case. To help them in their work, ALJs sometimes request expert testimony on complex medical issues from medical experts (MEs). Unlike medical consultants, medical experts have no official authority regarding whether you should be allowed benefits. Each Hearing Office maintains a list of medical experts who are called to testify as expert witnesses at hearings. The SSA pays the medical experts a fee for their services. Medical experts don't work in state or federal agencies. They never examine disability claimants in person, though they may review your medical records. (Appeals and medical experts are covered in Chapter 12.)

Life-Threatening Situations

If you undergo a DDS consultative examination (CE) at the expense of the SSA and the examining doctor detects something that might be life threatening, the DDS must send a copy of the CE medical report to your treating doctor, if it appears the treating doctor might be unaware of the problem. A DDS doctor may have an examiner call or write to you stating that there is a potentially serious problem you should have evaluated. In all cases, the DDS will include in your file any action it took regarding life-threatening situations.

In general, any doctor who examines you should inform you of any serious impairments. But the doctor might not do so if he assumes the DDS will tell you or if you are no longer around when the doctor gets the results of some test. For example, the DDS has you undergo a chest x-ray. By the time the report is done, but before the doctor can tell you about a suspicious and possibly cancerous tumor, you have left the hospital. A DDS medical consultant sees the x-ray report. The DDS medical consultant should ask the examiner to send a copy of the report to your treating doctor, provided you consent to the release. It is not the DDS consultant's job to speculate on the nature of an unknown abnormality or further evaluation or treatment. If you do not have a treating doctor or your treating doctor is someone you see infrequently, the DDS should tell you that you have an abnormality on your chest x-ray and should see a doctor.

In summary, it is the responsibility of the DDS or other SSA office that becomes aware of a life-threatening situation involving your health, and of which you apparently have no prior knowledge, to inform you that you need to seek medical care. A DDS medical consultant must exercise his medical judgment regarding the urgency of the situation and method of informing you, assuming that the examiner shows the information to a medical consultant.

Consultative examinations are also requested by disability hearing officers and administrative law judges. In these instances, your claim will often be decided without further review by any medical doctor—so there will be no medically qualified person to recognize a life-threatening situation that may have appeared since your last medical review.

D. How Other Disability Payments May Affect Social Security Benefits

Only workers' compensation benefits or benefits you receive from another public disability program affect the amount of Social Security disability benefits you receive.

1. Workers' Compensation and Public Disability

Workers' compensation payments are made to a worker because of a job-related injury or illness or to dependents if the worker is killed. Workers' comp, as it is known, may be paid by a government workers' compensation agency, an employer or an insurance company on behalf of employers. In most states, employers must participate in workers' compensation insurance programs. No state's law covers all jobs; however, some states cover most jobs. Some cover only work considered dangerous; some cover only employers with a minimum number of employees. Coverage varies for agricultural workers and domestic workers, meaning people who work in private homes doing work such as cleaning, baby-sitting and cooking. All laws include some or all diseases attributable to the worker's occupation. Most exclude injuries due to the employee's intoxication, willful misconduct or gross negligence.

Public disability payments that may affect your Social Security benefits are those paid under a federal, state or local government plan that covers conditions that are not job related. Examples are civil service disability benefits, military disability benefits, state temporary disability benefits and state or local government retirement benefits based on disability.



Workers' compensation and public disability benefit cases can be legally complex and vary between states, especially when combined with Social Security disability benefits. If you might be eligible for both, consider using the services of an attorney experienced in the interaction of Social Security disability and other programs to make sure you obtain all the benefits you are entitled to.

a. How Much Your Disability Benefits May Be Reduced

Your Social Security disability benefit will be reduced so that the combined amount of your Social Security benefit *plus* your workers' compensation and/or public disability payment does not exceed 80% of your average current earnings.

First, the SSA figures average current earnings. All earnings covered by Social Security, including amounts above the maximum taxable by Social Security, can be used when figuring average current earnings.

Average current earnings are the *highest* of the following:

- the average monthly earnings the SSA used to figure your Social Security disability benefit
- your average monthly earnings from any work you did covered by Social Security during the five highest years in a row after 1950, or
- your average monthly earnings from work during the year you became disabled or in the highest year of earnings you had during the five-year period just before you became disabled.

Your monthly Social Security disability benefit, including any benefits payable to your family members, is added to your workers' compensation or other public disability payment. If this sum exceeds 80% of your average current earnings, the excess amount is deducted from your Social Security benefit. But, the amount of the combined benefits will never be less than the total Social Security benefits before they were reduced. The reduction will last until the month you reach age 65 or the month your workers' compensation and/or other public disability payment stops, whichever comes first.

b. Reporting Other Benefits to the SSA

You must notify the SSA if any of the following occurs:

- The amount of your workers' compensation or public disability payment changes. This will probably affect the amount of your Social Security benefits.
- Your workers' compensation or public disability payment ends. If your workers' compensation or

public disability payment stops, your Social Security benefit usually will increase.

- You receive a lump-sum disability payment. If you get a lump-sum workers' compensation or other disability payment to settle your claim, your Social Security benefits may be reduced.

2. Railroad Retirement Act and Social Security Disability

The Railroad Retirement Act (RRA) sets up a system of benefits for railroad employees, their dependents and survivors. The RRA works with the Social Security Act to provide disability (as well as retirement, survivor and dependent) benefits payable on the basis of a person's work in the railroad industry and in work covered by the Social Security Act.

An important distinction is made between railroad workers who have worked fewer than ten years and those who have worked ten years or more. The RRA transfers to the Social Security system the compensation records of people who, at the onset of disability, have fewer than ten years of work in the railroad industry. This compensation is considered wages under the Social Security Act. The wages of those with ten or more years of work generally remain under the Railroad Retirement Act. The distinction has primary importance when you seek survivor's benefits based on the death of the insured railroad worker, and so the details are not covered here. But if it might apply to you, be aware of the distinction and ask your local SSA office for more information.

3. Black Lung Benefits and Social Security Disability

Black lung benefits are payments to coal miners—and their survivors—who become disabled from a lung disease known as pneumoconiosis as a result of breathing fine dust-like particles of coal while working in the mines. The Federal Coal Mine Health and Safety Act of 1969 assigned initial responsibility for processing black lung benefit claims to the SSA. The Labor Department assumed eventual responsibility.

If your disability claims arise out of your work in the mines, you can file your initial application with the SSA and let the SSA forward it to the Labor Department. You do not have to find a Labor Department office at which to file your claim.

The SSA has some responsibility for program administration and policy-making of black lung benefits. Furthermore, it handles black lung benefit appeals. But if you have any questions about black lung benefits, the SSA will refer you to the DOL.

4. What Payments Do Not Affect Your Social Security Disability Benefits?

The SSA does not count certain types of payments in considering whether to reduce your disability check. These include:

- Veterans Administration benefits
- federal benefits, if the work you did to earn them was covered by Social Security
- state and local government benefits, if the work you did to earn them was covered by Social Security
- private pensions or insurance benefits, and
- Supplemental Security Income (SSI) payments.

Also, the SSA should deduct legal, medical (including future medical expenses paid by workers' compensation) and rehabilitation expenses from a workers' compensation award before reducing your Social Security benefit.

E. Availability and Disclosure of Confidential Records

Several laws and regulations govern access to and disclosure of confidential information and official records entrusted to the SSA, the DDS and other nonfederal entities or individuals.

1. Your Medical Records

Under the Privacy Act, you or your authorized representative has the right to examine federal government

records pertaining to you (Public Law 93-579; 5 U.S.C. § 552a; 20 CFR §§ 401.30–401.200). Your authorized representative is someone you appoint in writing to pursue your rights under the Social Security Act. You don't have to name a complete stranger as your authorized representative; you could name any responsible person, including a family member.

This right means that you can request to see the medical and other evidence used to evaluate your application for SSDI or SSI benefits. Make this request in writing to the SSA Field Office handling your claim (see below for more details on the SSA procedure for releasing records). Medical records include:

- records kept by physicians or other health professionals
- records derived from reports by physicians or other health professionals
- medical evaluations and determinations on Social Security forms, including rationales and diagnoses, and
- records created by laypeople relevant to your claim (such as statements by witnesses who saw epileptic seizures or signs of mental impairment).

This law concerns your own requests to see your medical records. You cannot directly access your child's medical records. Instead, you must name a physician or other health professional (excluding family members) to receive the records as a designated representative.

The SSA will release your records to you as long as the SSA doesn't think they will have an *adverse effect* on you. According to the SSA, such an adverse effect is an effect likely to occur if direct access by an individual to his or her medical records is expected to:

- disrupt a doctor-patient relationship
- interfere with the patient's medical management, or
- negatively affect the patient in some other way.

Here are some of the SSA's own examples of adverse effect.

EXAMPLE 1: You have been diagnosed as diabetic. The medical record indicates a good prognosis with treatment involving medication, diet, weight

control and exercise. An adverse effect is not likely and the SSA is likely to release the records.

EXAMPLE 2: You have a severe heart impairment. The doctor has noted in the medical record that your knowing the severity of your condition could cause complications. An adverse effect is likely and the SSA is not likely to release the records.

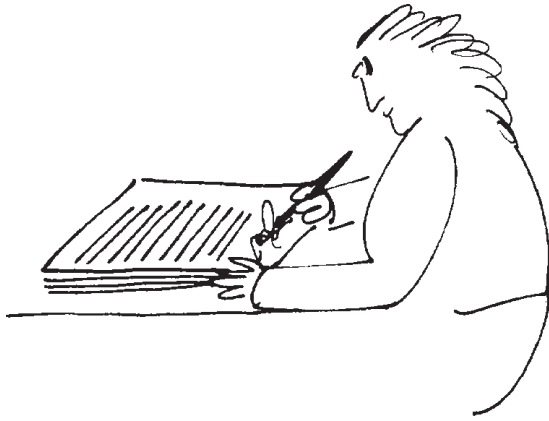
EXAMPLE 3: A doctor has included very candid remarks in the report that might incite you to threaten the doctor. An adverse effect is likely and the SSA is not likely to release the records.

There is one exception: direct disclosure of medical information may be made to you, upon request, in any case in which you have requested a hearing or a review by the Appeals Council.

The person at the SSA deciding whether or not you should see your medical records doesn't have to be a doctor. Nondoctors in SSA Field Offices can make that determination, or they can refer your file to doctors working for the SSA. If the SSA thinks that releasing your medical records will have an adverse effect on you, you won't be told. The SSA policy instruction specifically states: "Do not tell an individual that direct access of a medical record is likely to have an adverse effect on him/her."

Instead, you will be told that Privacy Act regulations require that you designate a representative to receive your records. Irony, isn't it? Under the law that is meant to protect your privacy, the SSA has concluded that someone other than you must get your records. You are not alone in thinking this sounds paternalistic and arrogant. Few people know about this policy because few people ask to see their medical records.

Until very recently, if you were forced to have a designated representative, that person could withhold any of your own records from you indefinitely. However, based on a federal court case against the SSA, your representative must ultimately provide all of your records to you. The SSA has not said, however, how long the representative has to turn over the records to the claimant.



Sample Letter When SSA Wants a Designated Representative

Dear [Claimant]:

You asked for copies of medical records we used in your *[type of]* claim. We reviewed the records. We decided that we must give them to someone you choose who will review and discuss the information with you. Because this is medical information, we prefer you choose a doctor or a health worker.

Please give us the name and address of the person you want to receive your medical records. You may use the office address shown above to send us this information.

If you have any questions, you may call, write or visit any Social Security office. If you call or visit our office, please have this letter with you and ask for *[Name of SSA Representative]*. The telephone number is *[xxx-xxx-xxxx]*.

If you receive a letter like the one above, the SSA clearly thinks that your seeing your records will have an adverse effect on you. If you do not follow through by naming a designated representative, the SSA will send you a form letter like the one below.

Sample Letter If You Don't Give a Designated Representative

Dear [Claimant]:

We are writing to you about your request for copies of medical records we used in your *[type of]* claim.

As we told you earlier, we require that you choose someone to receive your records. This person will review the information and discuss it with you. Because this is medical information, you may wish to choose a doctor or a health worker to review your records.

Since you have not yet chosen someone, we want to give you some suggestions about groups who might be able to help. We have found that the following groups are often willing to help people by reviewing their records:

- local social services
- local public health services
- legal aid societies, and
- other public agencies.

When you give us the name and address of the person you want to review your medical records, we will make sure they get the records. You may use the office address shown above to send us this information.

If you have any questions, you may call, write or visit any Social Security office. If you call or visit our office, please have this letter with you and ask for *[Name of SSA Representative]*. The telephone number is *[xxx-xxx-xxxx]*.

If you still don't name a representative, the SSA will mail your file to SSA's central Office of Disability (OD) in Baltimore. If this happens, you will have to wait months for a response to any further requests for your file.

2. Consultative Examination (CE) Records

The SSA may require that you be examined by a doctor or have laboratory tests done in order to evaluate your claim for disability. You must give permission for the SSA to obtain your medical records from your treating doctor and also for those records to be released to a doctor whom the SSA has chosen to do a CE exam.

Furthermore, the SSA cannot release the results of your CE exam to your treating doctor without your consent. It is generally to your benefit to have CE exams sent to your treating doctor. These CE exams often involve information your treating doctor doesn't have. Therefore, it is to your advantage to let your treating doctor see it.

But the SSA doesn't have to share the findings of your CE exam with you, except in life-threatening situations. (See sidebar, Life-Threatening Situations, in Section C, above.) Most claimants don't ask CE doctors for personal copies of their examinations or tests. If they do, the CE doctor must contact the DDS for permission to release the information.

3. Disclosure With Consent

Most disclosures by the SSA require your consent. Consent must be in writing, be signed by you or your authorized representative, be dated and specify what information is to be disclosed. Specifically, the SSA or DDS must obtain your consent in order to:

- contact your treating sources for information necessary to review your claim
- release your records, particularly your medical records, to the SSA, and
- disclose information about you to any third party, such as physicians and medical institutions, with the exception of parties permitted under disclosure without your consent. (See Section H4, below.)

In most situations, any consent statement you sign will include a revocation clause or else will be valid for only a specified time.

4. Disclosure Without Consent

Under the U.S. Privacy Act, the SSA can disclose your records without your consent for certain purposes. The SSA must keep a record of all such disclosures. Permissible reasons for disclosure without consent include the following:

- sharing information within an SSA agency on a need-to-know basis

- complying with the Freedom of Information Act (FOIA)
- for a routine use (a purpose compatible with the reason the information was collected, such as disability determination)
- assisting the Census Bureau in planing or carrying out a census, survey or related activity
- for research and statistical purposes
- transferring records to the National Archives of the United States when its historical or other value warrants its continued preservation
- cooperating with another government agency's civil or criminal law enforcement activity
- helping someone whose health and safety is affected by compelling circumstances (after notice of disclosure is sent to you)
- informing the House of Representatives or the Senate, to the extent necessary on a matter within its jurisdiction
- cooperating with the Comptroller General while performing duties of the General Accounting Office, or
- a court order.

More specific examples of disclosures that are covered under the above list include the following:

- information to your representative payee (the person designated to receive your payments) or authorized representative to pursue a Social Security claim or to receive and account for payments
- medical information to your designated representative
- payment information to the IRS to conduct an audit, collect Social Security taxes or investigate a tax crime
- information to the Justice Department or U.S. Postal Service for law enforcement purposes, or
- nontax return information (and usually non-medical information) to the President, individual members of Congress and their staffs if necessary to answer inquiries from you or your authorized representative.

Finally, if the SSA sends your records to someone without your consent, the SSA does not have to inform you of that action.

5. Penalties for Violating Disclosure Laws

Your privacy rights are protected by a variety of federal statutes.

Social Security Act. Under the Social Security Act, the following violations are punishable as misdemeanors by a fine of up to \$1,000 and/or a year in prison:

- disclosure by an SSA employee of tax return information, files, records, reports or other SSA papers or documents, except as permitted by regulation or federal law, or
- misrepresentation by an individual who purports to be an employee or agent of the United States, with the intent to elicit information regarding another person's date of birth, employment, wages or benefits.

Freedom of Information Act (FOIA). The FOIA provides that agency officials found to have arbitrarily and capriciously withheld disclosable records may be subject to disciplinary action recommended by the Special Counsel to the Merit Systems Protection Board.

Privacy Act (PA). You can sue the SSA in a U.S. District Court for various reasons, including:

- refusing to amend your Social Security record
- refusing to let you (or another person chosen by you) view your record and obtain a copy of it
- failing to disclose that you dispute information in your record, or
- failing to accurately maintain your record.

If the court determines that the SSA acted intentionally or willfully, it may assess against the United States the attorney fees, other litigation costs and actual damages you sustain. The court can award you at least \$1,000 in damages in such cases.

The SSA might be found guilty of a misdemeanor, mostly due to the willful disclosure of information in violation of the PA. You cannot normally bring criminal actions against an employee of the SSA. You must convince the Justice Department that an employee “willfully and knowingly” disclosed information. If convinced, the DOJ may prosecute.

Finally, an SSA employee may be subject to disciplinary action for knowing and willful violations of the PA.

Internal Revenue Code (IRC). Under the IRC, a federal employee who discloses information found on a fed-

eral tax return may be guilty of a felony and fined \$5,000 and sentenced to five years in prison or both. Furthermore, you can sue the IRS and any person who knowingly or negligently discloses federal tax returns or return information.

Alcohol and Drug Abuse Patient Records. Any person who violates the Drug Abuse and Treatment Act or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act by disclosing such information may be fined as much as \$500 for a first offense and as much as \$5,000 for each subsequent offense.

6. Reporting Possible Violations

If you suspect a violation of one of the above laws involving an SSA employee, report the incident to the employee's supervisor or call the SSA's Office of Inspector General (OIG) Hotline. The telephone numbers are: 800-638-5779 (outside Maryland), and 800-638-3986 (in Maryland). You can also write to the SSA on the Internet at www.ssa.gov, where you will find a link to the Inspector General.

F. Fraud and Other Crimes

Both SSA personnel and DDS officers are looking for fraud—for example, allegations of disability that are not consistent with other information and indications that an individual may have been coached.

The SSA says fraud has occurred when someone, with the intent to wrongfully obtain a benefit, right or credit, knowingly makes a false statement, causes a false statement to be made, willfully attempts to conceal a material fact or fails to disclose a material fact (§§ 208 and 1632 of the Social Security Act).

Claimants have been known to allege impairments they do not have. Sometimes this is innocent. Sometimes it is not, such as when a person alleges a serious illness where medical records show no such diagnosis. Some treating doctors lie about a person having a serious illness. Some doctors' medical records show they know the diagnoses given to the SSA are not valid.

The SSA rarely goes after treating doctors or claimants for fraud. This may be because the SSA needs the

goodwill of the public and medical profession, or because it is difficult to prove intentional lies. But the SSA doesn't ignore fraud. It ignores statements it knows are false when making the disability determination.

The SSA may identify fraud anywhere in the claims process. If the SSA identifies fraud after determining that a person is eligible for benefits, the SSA can reopen the file and redo the determination, ignoring the false information.

It is a crime to do any of the following:

- furnish false information in connection with your Social Security records or to obtain someone else's records
- use an SSN obtained through false information
- use someone else's SSN
- disclose or force the disclosure of or use an SSN in violation of U.S. law
- forge or falsify SSA documents
- conspire over a false claim
- knowingly buy, sell or alter an SSN card, or
- process an SSN card or counterfeit an SSN card.



Chapter 3

Disability Benefits For Children

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About one million children receive disability benefits from the Social Security Administration (SSA). This chapter is for the parents and caregivers of children—generally considered to be people under the age of 18—with disabilities, and for the parents and caregivers of adults who have been disabled since childhood. Although some of this information appears in other chapters, we bring it together here to provide one place for important information needed by caregivers of children. The person who handles the benefits on behalf of a child is called, in Social Security lingo, the *representative payee*, and must be a responsible person. The representative payee is usually a child's parents.



The representative payee is not the same as the authorized representative. An authorized representative is any person, including an attorney, named in writing by the claimant/recipient, to act in place of the claimant/recipient in pursuing his or her rights under the Social Security Act.

You can use the information in this chapter to understand the kinds of Social Security Disability (SSDI) and Supplemental Security Income (SSI) available to an eligible child and to learn how the Social Security Administration (SSA) evaluates disability claims for children.

A. Three Benefit Programs for Children

There are three ways a child might be eligible for SSDI or SSI benefits.

1. SSDI Benefits for Children Under 18

Social Security dependents' benefits are available to children under the age of 18 based *on the record* of a parent who collects Social Security retirement or disability benefits. Social Security survivors' benefits are available also to children under the age of 18 based *on the record* of a deceased parent who received Social Security retirement or disability benefits. *On the record* means benefits are paid based on the earnings

records of someone else—the insured worker who paid enough Social Security taxes to qualify for SSDI benefits. *Parent* means the biological parent, adoptive parent or stepparent.

While this is a book about disability benefits, children eligible for dependents "or survivors" benefits need not be disabled. A child is eligible for Social Security benefits simply because she is the dependent of someone receiving disability benefits or the surviving child of someone who died while receiving benefits. Once a child is found eligible for these benefits, she can receive them until she turns 18—or 19 if she is a full-time student in elementary or high school.

Twice a year—at the beginning and end of the school year—the SSA sends the student a form asking whether the child is still in school. The SSA may terminate benefits if the student (or living parent) doesn't send back a completed form. If the child turns 19 during a school term, the SSA can continue the benefits for up to two months to allow the student to complete the term. Before turning 19, a student may receive benefits during a vacation period of four months or less if she plans to go back to school full-time at the end of the vacation.

If the student leaves school, changes from full-time to part-time or changes schools, you must notify the SSA immediately. Also let the SSA know if the student is paid by her employer for attending school. A student who stops attending school generally can receive benefits again if she returns to school full-time before age 19. The student must contact the SSA to reapply for benefits.

If your stepchild receives benefits on your earnings record, and you and the child's parent divorce, the stepchild's benefit will end the month following the month the divorce becomes final. (This is not the case with biological or legally adopted children.) You must notify the SSA as soon as the divorce becomes final.

Child dependents' and survivors' benefits are known as *auxiliary benefits*, because they are based on the disability and earning record of a parent. The theory behind the benefits is that a disabled parent needs more money to take care of dependent children, and that a surviving spouse of a deceased disabled worker needs more money to take care of children. Auxiliary benefits are discussed in Chapter 1, Section A1.

2. SSDI Benefits for Adults Disabled Since Childhood

Social Security dependents' or survivors' benefits normally end when a child reaches age 18, or age 19 if the child is a full-time student. If the young adult is disabled, however, the benefits can continue as long as the recipient is disabled.

The rules require that:

- the disability began prior to age 22, and
- the recipient be the child of someone receiving Social Security retirement or disability benefits or of someone who received Social Security retirement or disability benefits but is now deceased.

Someone who qualifies is said by the SSA to be an "adult child" or "adult disabled since childhood."

Although most recipients of these benefits are in their 20s and 30s, the benefit is considered a "child's benefit" because of the eligibility rules.

Sometimes, a person doesn't become eligible for a disabled "child's benefit" until well into adulthood.

EXAMPLE: John retires and starts collecting Social Security retirement benefits at age 62. He has a 38-year-old son, Ben, who has had cerebral palsy since birth. Ben could not collect Social Security benefits earlier because John was still working and not collecting benefits. When John retired, however, Ben started collecting a disabled child's benefit based on John's Social Security record.

3. SSI Benefits

SSI is a program that pays monthly benefits to elderly and disabled people with low incomes and limited assets. Children under the age of 18 can qualify for SSI if they meet the SSA's definition of disability (see Section C, below) and if their income and assets—or more likely, the income and assets of their parents—fall within the eligibility requirements. The requirements vary from state to state. Check with your local Social Security office to find out the SSI eligibility levels in your state. (You can call 800-772-1213 from 7 a.m. to 7 p.m. Monday through Friday to find the location of

an SSA office near you, or access the Internet at www.ssa.gov/regions/regional.html.)

When a child turns 18, the SSA considers him an adult. His eligibility for SSI is no longer determined under the rules for children. For example, his parent's income and assets are not relevant in deciding if he is eligible to receive SSI. Instead, his own income and resources are used to determine eligibility. This means that a child who was not eligible for SSI before his 18th birthday because his parents' income and assets were too high may become eligible as an adult when he reaches age 18. Of course, this assumes his own income and resources are low enough, so that he qualifies under the adult medical disability criteria and he satisfies all other eligibility requirements for disability benefits.

Note that if the young adult at age 18 still receives food and shelter paid for by his parents, the government considers these as benefits, which may result in a lower disability benefit payment, even if he qualifies as a medically disabled adult.

B. Applying for SSDI or SSI Benefits

You can apply for SSDI or SSI benefits for your child by calling or visiting your local SSA office. Bring the child's Social Security card—or at least the number—and birth certificate with you. If you are applying for SSI for your child, you also will need to provide records that show your income and your assets, as well as those of the child.

You will be sent or given SSA-3820-BK to fill out. We provide a sample form here. Look at the form to see what information you will need to gather to fill it out.



You must use forms provided by the SSA. You can obtain them at your local SSA Field Office or by calling the SSA hotline at 800-772-1213, Monday through Friday (except holidays), from 7 a.m. to 7 p.m. If you are deaf or hard of hearing, TTY service representatives are available at the same times at 800-325-0778. You can also download many necessary forms from the SSA website at www.ssa.gov.

SSA-3820-BK, Disability Report—Child (Page 1)

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0577**DISABILITY REPORT — CHILD****SECTION 1 — INFORMATION ABOUT THE CHILD****A. CHILD'S NAME** (First, Middle Initial, Last)

Penny A. Reeves

B. CHILD'S SOCIAL SECURITY NUMBER

345-67-8901

C. YOUR NAME (If agency, provide name of agency and contact person)

Marilyn Reeves

YOUR MAILING ADDRESS (Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)

4301 W. Markham Street

CITY

Oklahoma City

STATE

OK

ZIP CODE

73999

D. YOUR DAYTIME PHONE NUMBER (If you have no phone number, give us a daytime number where we can leave a message for you.)405

Area Code

555-1111

Number

☒

Your Number

☐

Message Number

☐

None

E. What is your relationship to the child? parent/mother**F. Can you speak English?** YES ☒ NO ☐ If "NO," what languages can you speak?If you **cannot speak English**, is there someone we may contact who speaks English and will give you messages?

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

DAYTIME
PHONE

Area Code

Number

Can you **read English**? YES ☒ NO ☐**G. Does the child live with you?** YES ☒ NO ☐ If "NO," with whom does the child live?

NAME _____ RELATIONSHIP TO CHILD _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

DAYTIME
PHONE

Area Code

Number

Can this person **speak English**? YES ☐ NO ☐

If "NO," what languages can this person speak? _____

Can this person **read English**? YES ☐ NO ☐

SSA-3820-BK, Disability Report—Child (Page 2)

SECTION 1 — INFORMATION ABOUT THE CHILDH. Can the child speak English? YES ☒ NO ☐

If "NO" what languages can the child speak? _____

I. What is the child's height (*without shoes*)? 56 in What is the child's weight (*without shoes*)? 80 lbs.J. Does the child have a **medical assistance card**? (for example Medicaid, Medi-Cal)YES ☐ NO ☒If "YES," show the **number** here: _____**SECTION 2 — CONTACT INFORMATION**

a person that we can contact (other than the child's doctors, such as legal guardian) who knows about the child's illnesses, injuries or conditions and can help you with his/her claim.

NAME OF CONTACT Marilyn ReevesADDRESS 4301 W. Markham Street
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)Oklahoma City OK 93999
City State ZIPDAYTIME PHONE NUMBER 405 555-1111
Area Code NumberRELATIONSHIP TO CHILD parent/mother**SECTION 3 — THE CHILD'S ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT HIM/HER**A. What are the child's disabling **illnesses, injuries, or conditions**? _____mental retardation, heart diseaseB. How do the child's illnesses, injuries or conditions **limit his/her daily activities**? slow learner, needsspecial teacher at school; gets short of breath trying to play with other childrenand gets tiredC. When did the child **become** disabled?

<i>Month</i>	<i>Day</i>	<i>Year</i>
April	14	1992

D. Do the child's illnesses, injuries or conditions cause **pain**? YES ☐ NO ☒

SSA-3820-BK, Disability Report—Child (Page 3)

SECTION 4 — INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnessess, injuries or conditions?

YES ☒ NO ☐

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

YES ☒ NO ☐

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List **each DOCTOR/HMO/THERAPIST**. Include the child's **next appointment**.

1.	NAME Dr. Jessica Cook, psychologist	DATES	
	STREET ADDRESS 1001 Polk Street	FIRST VISIT Nov. 1993	
	CITY Oklahoma City STATE OK ZIP 73888	LAST SEEN April 2001	
	PHONE 405 555-3333 CHART/HMO # Area Code Number don't know	NEXT APPOINTMENT July 2002	
	REASONS FOR VISITS mental retardation		
	WHAT TREATMENT WAS RECEIVED? mental tests and advice about Penny's behavior and limitations		
2.	NAME Dr. John Barrow	DATES	
	STREET ADDRESS 95 Capitol Avenue	FIRST VISIT April 1992	
	CITY Oklahoma City STATE OK ZIP 73887	LAST SEEN July 1992	
	PHONE _____ CHART/HMO # Area Code Number	NEXT APPOINTMENT None	
	REASONS FOR VISITS Evaluation of Penny's heart problem		
	WHAT TREATMENT WAS RECEIVED? Heart surgery to repair defects present at birth		

SSA-3820-BK, Disability Report—Child (Page 4)

SECTION 4 — INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS**DOCTOR/HMO/THERAPIST**

3. NAME <u>Dr. Peggy Hall</u>		DATES	
STREET ADDRESS <u>975 Fairview Drive</u>		FIRST VISIT <u>April 1992</u>	
CITY <u>Oklahoma City</u>	STATE <u>OK</u>	ZIP <u>73888</u>	LAST SEEN <u>Oct. 2001</u>
PHONE <u>405</u> <u>555-4444</u>	CHART/HMO #		NEXT APPOINTMENT <u>March 13, 2002</u>
REASONS FOR VISITS <u>regular medical check-ups. Dr. Hall is Penny's pediatrician</u>			
WHAT TREATMENT WAS RECEIVED? <u>immunizations, treatment of colds and other problems children have. Also prescribes drugs for Penny's heart condition.</u>			

If you need more space, use Remarks, Section 10.**D. List each HOSPITAL/CLINIC. Include the child's next appointment.**

1. HOSPITAL/CLINIC		TYPE OF VISIT	DATES	
NAME <u>Children's Hospital</u>	☒ INPATIENT STAYS (Stayed at least overnight)	DATE IN	DATE OUT	
STREET ADDRESS <u>183 Popular Avenue</u>		<u>April 1992</u>	<u>May 1992</u>	
Oklahoma City OK 93888 CITY STATE ZIP	☐ OUTPATIENT VISITS (Sent home same day)	DATE FIRST VISIT	DATE LAST VISIT	
PHONE <u>405</u> <u>555-5555</u>				
	☒ EMERGENCY ROOM VISITS	DATES OF VISITS		
		<u>July 1993</u>		

Next appointment none The child's hospital/clinic number unknownReasons for visits Penny's heart had irregular rhythm and she was short of breathWhat treatment did the child receive? oxygen and drugs to make her heart rhythm regularWhat doctors does the child see at this hospital/clinic on a regular basis? Dr. Hall

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SECTION 4 — INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2. HOSPITAL/CLINIC		TYPE OF VISIT		DATES	
NAME		☐ INPATIENT STAYS <i>(Stayed at least overnight)</i>	DATE IN		DATE OUT
STREET ADDRESS		☐ OUTPATIENT VISITS <i>(Sent home same day)</i>	DATE FIRST VISIT		DATE LAST VISIT
CITY	STATE	☐ EMERGENCY ROOM VISITS	DATES OF VISITS		
ZIP					
PHONE					
Area Code Number					

Next **appointment** _____ The child's hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did the child receive? _____

What **doctors** does the child see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 10.

E. Does **anyone else** have medical records or information about the child's illnesses, injuries or conditions (Workers' Compensation, insurance companies, counselors, detention centers, attorneys, and/or tutors), or is the child scheduled to see anyone else?

YES ☐ (If "YES," complete information below.) NO ☒

NAME			DATES	
ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN	
PHONE			NEXT APPOINTMENT	
Area Code Number				
CLAIM NUMBER (If any) _____				
REASONS FOR VISITS? _____				

If you need more space, use Remarks, Section 10.

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SECTION 5 — MEDICATIONS

Does the child currently take any **medications** for illnesses, injuries or conditions?
If "YES," tell us the following. *(Look at the child's medicine bottles, if necessary.)*

YES ☒ NO ☐

NAME OF MEDICINE	PRESCRIBED BY (Name of Doctor)	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS
Digitalis	Dr. Hall	irregular heart	

If you need more space, use Remarks, Section 10.

SECTION 6 — TESTS

Has the child had, or will he/she have, any **medical tests** for illnesses, injuries or conditions?

YES ☒ NO ☐ If "YES," tell us the following (give approximate dates, if necessary).

KIND OF TEST	WHEN DONE, OR WHEN IT WILL BE DONE (Month, day, year)	WHERE DONE (Name of facility)	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)	1992, 1993 yearly	Children's Hosp. 1992 others in Dr. Hall's office	Dr. Hall
TREADMILL (EXERCISE TEST)	None		
CARDIAC CATHETERIZATION	1992	Children's Hosp.	Dr. Barrow
BIOPSY Name of body part _____	None		
SPEECH/LANGUAGE	Currently	Fair Park School	School
HEARING TEST	Yes. Don't remember date	Dr. Hall's Office	Dr. Hall
VISION TEST	Yes. Don't remember date	Dr. Hall's Office	Dr. Hall
IQ TESTING	1993, 1995, 2000	Dr. Cook's Office	Dr. Cook
EEG (BRAIN WAVE TEST)	1992	Children's Hosp.	Dr. Hall
HIV TEST	None		
BLOOD TEST (NOT HIV)	1992 and other times	Children's Hosp. and Dr. Hall's Office	Dr. Hall
BREATHING TEST	None		
X-RAY Name of body part <u>Chest</u>	1992 and other times	Dr. Hall's Office	Dr. Hall
MRI/CAT SCAN Name of body part _____	None		

If the child has had other tests, list them in Remarks, Section 10.

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SECTION 7 — ADDITIONAL INFORMATION

A. Has the child been **tested or examined** by any of the following?

Headstart (Title V)	YES	☐	NO	☒
Public or Community Health Department	YES	☐	NO	☒
Child Welfare or Social Service Agency	YES	☐	NO	☒
Women, Infant and Children (WIC) Program	YES	☐	NO	☒
Program for Children with Special Health Care Needs	YES	☐	NO	☒
Mental Health/Mental Retardation Center	YES	☒	NO	☐
Vocational Rehabilitation	YES	☐	NO	☒
If "NO," and over age 15, do you want to be referred to Vocational Rehabilitation?	YES	☐	NO	☐

B. If you answered "YES" to any of the above, complete the following:

1. NAME OF AGENCY Community Mental Health Center (Dr. Cook)

ADDRESS 1001 Polk Street
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

Oklahoma City OK 93888
City State ZIP

PHONE NUMBER 405 555-6666
Area Code Number

TYPE OF TEST IQ test WHEN DONE 1993, 1995, 2000

TYPE OF TEST achievement test WHEN DONE don't remember

FILE OR RECORD NUMBER don't know

2. NAME OF AGENCY _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City State ZIP

PHONE NUMBER _____
Area Code Number

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

If there are any other agencies, show them in Remarks, Section 10.

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SECTION 8 — EDUCATION

A. What is the child's **current grade** in school or the **highest grade** completed? in 3rd grade

B. Is the child currently attending school (*other than summer school*)? YES ☒ NO ☐

If "NO" explain why the child is not attending school. _____

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL Peabody Elementary School

ADDRESS 2500 Pine Street

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

Oklahoma City OK 93777

City County State ZIP

PHONE NUMBER 405 555-7777

Area Code Number

DATES ATTENDED 1998-current

TEACHER'S NAME Ms. Harrison

Has the child been tested for behavioral or learning problems? YES ☒ NO ☐

If "YES," complete the following:

TYPE OF TEST IQ WHEN DONE Don't remember—

various times

TYPE OF TEST _____ WHEN DONE _____

Is the child in special education? YES ☒ NO ☐

If "YES," and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech therapy? YES ☒ NO ☐

If "YES," and different from above, give:

NAME OF SPEECH THERAPIST Ms. Rodriquez

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SECTION 8 — EDUCATION

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

County

State

ZIP

PHONE NUMBER _____

Area Code

Number

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems? YES ☐ NO ☐

If "YES," complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Was the child in Special Education? YES ☐ NO ☐

If "YES," and different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech therapy? YES ☐ NO ☐

If "YES," and different from above, give:

NAME OF SPEECH THERAPIST _____

If there are other schools, show them in Remarks, Section 10.

E. Is the child attending Daycare/Preschool? YES ☐ NO ☒

If "YES," complete the following:

NAME OF DAYCARE/
PRESCHOOL/CAREGIVER _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

County

State

ZIP

PHONE NUMBER _____

Area Code

Number

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

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SECTION 9 — WORK HISTORY

A. Has the child ever worked (including sheltered work)? YES ☐ NO ☒

If "YES", complete the following:

DATES WORKED _____

NAME OF EMPLOYER _____

ADDRESS _____

(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City

State

ZIP

PHONE NUMBER _____

Area Code

Number

NAME OF SUPERVISOR _____

B. List job title, and briefly describe the work and any problems the child may have had doing the job.

SECTION 10 — REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

Penny tires easily, and is frustrated by not being able to learn as fast as other
children. Her teachers say she is falling further and further behind in her school work.
Dr. Hall says Penny's heart is becoming more irregular and increasing in size. She says
Penny needs more tests in the hospital and might even need surgery again, but I can't
afford the costs.

SECTION 10 — REMARKS

PAGE 11

If the child meets initial eligibility requirements, the child's file is forwarded to a state agency called the Disability Determination Service (DDS). There, a disability evaluation team, made up of a nondoctor examiner and a medical consultant, reviews the child's case to decide if she meets the SSA's definition of disability. (See Chapter 6 for more on DDS agencies, examiners and medical consultants.)

The doctors at the DDS need thorough and detailed medical records to help them decide if your child is disabled. You can speed up the process by providing your child's medical records to the SSA, or more likely, helping the SSA get them. When you fill out the application for your child, you will be asked to provide names, addresses and telephone numbers of all doctors, hospitals, clinics and other specialists your child has visited. Be as thorough as you can. If you have them, provide the dates of visits to doctors and hospitals, insurance policy numbers and any other information that will help the SSA get your child's medical records as soon as possible.

In addition, if your child is under age 18 and applying for SSI, you will be asked to describe how your child's disability affects his or her ability to function like a child of similar age. To help the DDS in its evaluation, be ready to provide the names of teachers, day care providers and family members who can give information about how your child functions in his or her day-to-day activities. If you can get any school records, bring them along.

In many communities, the SSA has made special arrangements with medical providers, social service agencies and schools to help it get the information it needs to process your child's claim. Most DDSs have Professional Relations Officers who work directly with these organizations. But don't rely solely on these officers to get the information. It's your child; you need to be an active participant in your child's quest for benefits.

C. Disability Evaluation

As explained previously, the SSA considers anyone under age 18 a child. Under SSI, children can qualify for disability based on their own medical problems. Under SSDI, children can receive benefits at any age (paid to the parents) if the parent is a disabled, retired or de-

ceased worker who has paid sufficient Social Security taxes. Such SSDI children *cannot* receive benefits based on their own medical problems, no matter how severe. A child of an eligible worker can receive benefits based on her own medical problems, however, once she passes her 18th birthday, as long as she becomes medically disabled before age 22.

All claimants, both children and adults, must pass through a specific set of disability evaluation steps called sequential evaluation. (See Chapter 7 for more on this process.)

1. Disability in Adult Children for SSDI

A child over 18 years of age who is applying for SSDI disability for the first time or being converted from an SSDI child's benefit will be evaluated using the adult disability criteria. It is important to remember that these claimants are adults, not children, and that their nonmedical eligibility depends on having a parent worker who is insured for SSDI benefits by having paid enough Social Security taxes. Briefly, to qualify for disability, an adult must have a physical or mental impairment that is expected to keep him from doing any substantial work for at least a year or is expected to result in death. Generally, if the claimant holds a job that pays \$800 or more per month, the work is considered substantial. (See Chapter 1, Section B, for more on defining disability.)

The claimant's condition is compared to a list of impairments that are considered to be severe enough to prevent him from working for a year or more. These are called the Listing of Impairments. If the claimant is not working and has an impairment that is on the list or equivalent to a condition on the adult listing, he is considered disabled for Social Security purposes. (For more on SSA listings, see Section C2 below.)

If the DDS cannot match the claimant's impairment with one on the list, the DDS assesses his ability to perform the type of work he did in the past—if any. A young adult usually won't have a past work history, so the DDS considers his ability to do any kind of work for which he is suited—based on age, education and experience. If he is found to be unable to do any substantial work, then he qualifies for SSDI benefits. (For more information on this issue, see Chapter 7.)

2. Disability in Children for SSI

A child's disability obviously cannot be evaluated using work-related adult criteria. Instead, a child will be considered disabled if she satisfies all nonmedical eligibility rules, and has an impairment that is medically both *marked* and *severe*.

All the medical records you provide or SSA obtains are forwarded to the DDS. If the available records are not thorough enough for the DDS team to decide if your child qualifies as disabled, you may be asked to have your child undergo a special examination called a consultative examination, or CE, which is paid for by the government.

a. Marked and Severe

Marked and severe is a legal standard in the Social Security Act. It applies to the disabling conditions that either satisfy a specific medical requirement listing or result in equivalent functional limitations. (The Listings are discussed further in Section C2, below, and appear in Chapters 16 through 29.) The phrase is meant to emphasize the intent of Congress to grant disability benefits only to children with the worst medical conditions. When used by the SSA, marked and severe has a more specific meaning—to indicate whether a child's impairments are disabling enough to qualify under a specific listing in the Listing of Impairments.



Defining Marked and Severe

Marked means more than moderate and less than extreme. The Listings authorize the granting of benefits when a child's condition causes marked limitations in two areas of functioning or extreme limitations in one area of functioning. The exact areas of functioning depend on the type of impairment. For example, the ability to walk and use the hands is important in arthritis and nervous system disorders. In mental disorders, memory, ability to relate to other people and ability to think clearly are important. Limitations in function are considered in light of what is age appropriate. The SSA requires that their doctors use medical judgment in making these decisions.

Severe means a condition that is more than mild or slight. A condition that is only mild or slight is called not severe or nonsevere by the SSA. Keep in mind that the common meaning of severe implies a medical condition worse than moderate, but the SSA requires only worse than mild or slight. (See Chapter 7 for a more detailed explanation of severe.)

Some listings mention medical severity rather than functional severity because they presume that extreme functional limitations will result from the disorder. For example, if a child has been diagnosed with acute leukemia, the child will meet the listing and be granted benefits without considering functional limitations.

b. Child Listing of Impairments

A DDS medical consultant initially checks to see if the child's medical condition is on the Listing of Impairments found in the Social Security regulations, or if the child has an impairment of equivalent severity. These listings say what sort of symptoms, signs or laboratory findings show that a physical or mental condition is severe enough to disable a child. If your child's condition is on the list or equivalent to something on the list, your child is considered disabled for SSI purposes.

In comparing your child's condition against the Listing of Impairments, the medical consultant reviews evidence from doctors and other health professionals who treat your child, as well as teachers, counselors,

therapists and social workers. All of these people have knowledge of how your child functions day-to-day and how your child has functioned over time. (See Chapters 16 through 29 for the SSA listings.)

Is Your Child in Special Education?

Your child will not be automatically found disabled for SSI purposes because he is enrolled in special education classes. At the same time, just because your child is mainstreamed does not automatically mean that he won't be found disabled for SSI purposes. The DDS evaluation is based on different criteria.

c. Special Rules for Children With Severe Disabilities

The disability evaluation process generally takes several months. But the SSI eligibility law includes special provisions for people, including children, whose condition is so severe that they are presumed to be disabled. In these cases, SSI benefits begin immediately and are paid for up to six months while the formal disability decision is being made. (The child must, of course, meet the other nonmedical eligibility requirements.) These payments are called *presumptive disability payments*. (See Chapter 4 for more details.)

If the SSA makes these payments and later decides that the child's disability is not severe enough to qualify for SSI benefits, the money does not have to be paid back.

d. Special Rules for Children With HIV Infection

Children with HIV infection may differ from adults in the way the infection is acquired and in the course of the disease. DDS disability examiners and doctors have been provided with extensive guidelines to use when evaluating claims for children with HIV infection.

Some children may not have the conditions specified in the SSA's current guidelines for evaluating HIV infection, but may have other signs and symptoms that indicate an impairment that affects their ability to

engage in activities expected of children of the same age. This kind of evidence may help show that your child is disabled for SSI purposes. (See Chapter 29 for more detailed discussion of children with HIV and AIDS.)

D. Continuing Disability Reviews for SSI Children

The law requires that the SSA periodically do a continuing disability review (CDR) to determine whether or not a child under age 18 is still disabled. The CDR must be done on the following schedule:

- at least every three years for recipients under age 18 whose conditions are likely to improve
- not later than 12 months after birth for babies whose disability is based on low birth weight, and
- sometime during the 18th year, if the person received benefits for at least one month before turning age 18 (after turning 18, the eligibility will be based on the adult criteria).

Continuing disability reviews for SSI recipients under age 18 whose conditions are not likely to improve are done at the discretion of the SSA. Despite legal requirements, the SSA frequently stops doing CDRs when the agency is short of money. This means that actual intervals for CDRs may be longer than described above.

One thing you must show during a CDR is that the child is and has been receiving treatment considered medically necessary and available for her disabling condition. The only time the SSA does not require this evidence is if the agency determines that it would be inappropriate or unnecessary. If the SSA requests this evidence and you refuse to provide it, the SSA will suspend payment of benefits to you and select another representative payee if that would be in the best interest of the child. If the child is old enough, the SSA may pay the child directly. Generally, if the child is under age 18, the SSA will make payments only to a representative payee. Under certain circumstances, however, the SSA will make direct payments to a beneficiary under age 18 who shows the ability to manage such benefits. These circumstances are:

- The child beneficiary is also a parent and files for herself and/or her child, and has experience in handling her own finances.
- The child is capable of using the benefits to provide for her needs and no qualified payee is available. (Whether the child is “capable” is a matter of judgment on the part of the SSA.)
- The child is within seven months of reaching age 18 and is filing an initial claim for benefits.

CDRs are discussed further in Chapter 14.

E. Other Healthcare Concerns

Federal law recognizes that disabled children need more than simply monthly cash benefits for their healthcare. Some types of healthcare assistance available to disabled children are summarized below, and are especially directed toward helping children who receive SSI.

1. Medicaid

Medicaid is a healthcare program for people with low incomes and limited assets. In most states, children who receive SSI also qualify for Medicaid. In many states, Medicaid comes automatically with SSI eligibility. In other states, you must sign up for it. And some children can qualify for Medicaid coverage even if they don't qualify for SSI. Check with your local Social Security office or your state or county social services office for more information.

2. Medicare

Medicare is a federal health insurance program for people 65 or older or who have received SSDI benefits for at least two years. Because children do not get SSDI benefits until they turn 18 (if they qualify at a younger age they are receiving dependents' or survivors' benefits through their parents), no child can get Medicare coverage until he or she is 20 years old. The only exception is for children with chronic renal disease who need a kidney transplant or maintenance dialysis. And those children will be eligible for Medicare only if a parent receives SSDI or has worked enough to be covered by Social Security.

3. Children With Special Healthcare Needs

If the SSA determines that a child is disabled and eligible for SSI, the SSA refers the child for healthcare services under the Children with Special Health Care Needs (CSHCN) provision of the Social Security Act. CSHCN services are generally administered through state-run health agencies, and most provide specialized services through arrangements with clinics, private offices, hospital-based outpatient and inpatient treatment centers or community agencies.

Depending on your state, the CSHCN program may be called the Children's Special Health Services, Children's Medical Services, the Handicapped Children's Program or something else. Even if your child is not eligible for SSI, you may be able to obtain some kind of health service for your child through a CSHCN program. Contact a local health department office, social services office or hospital to find out how to contact your CSHCN program.

4. Children in Certain Medical Care Facilities

Living in a public institution may affect an SSI claimant's or recipient's eligibility and payment amount. That's because residents of public institutions generally are not eligible for SSI. For SSI purposes, a public institution is one operated by or controlled by a federal, state or local government agency, and housing 17 or more residents.

There are exceptions to this rule. If a child lives for an entire month in a public institution or private medical care facility where more than 50% of the costs are covered by private insurance, Medicaid or a combination of the two, the child may be eligible for a \$30 monthly SSI payment (20 CFR §416.211 (b)(1)(i)(ii)). This exception also applies if a child spends part of a month in a public institution and part in a private medical facility where more than 50% of the costs are covered by private insurance, Medicaid or a combination of the two. Medical facilities are hospitals, skilled nursing facilities and intermediate care facilities. There is no limitation on the SSI payment if the child is in a private facility and does not receive or expect to receive more than 50% of the

cost of the child's care from private insurance or Medicaid (Program Operations Manual System (POMS) SI 00520.001).

EXAMPLE: Matthew, a disabled child, was born at Tall Oaks Multi-Care Center on October 4. He remained in the hospital until January 5, when he was released to live with his parents at home. Private health insurance paid for more than 50% of the cost of Matthew's care for the months of October and November. For December and January, more

than 50% of the cost of his care was paid for by a combination of private insurance and Medicaid. Matthew is eligible for the \$30 per month benefit.

Because of the complexity of laws involving SSI for children living in institutions, call your local Social Security Field Office if your disabled child who receives SSI is going to be in a facility. In fact, the SSA requires that you report if your child is admitted or discharged from a medical facility or other institution. (See Chapter 13 for details.) ■

Chapter 4

Getting Benefits During the Application Process

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B. Impairments Qualifying for Presumptive Disability by Field Office	4/3
1. Observation	4/3
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C. Qualifying for Presumptive Disability Through the DDS	4/5
1. High Potential for Presumptive Disability	4/5
2. Caution in Granting PD	4/5
3. Low Potential for PD	4/5

Presumptive disability (PD) payments are made to a person who is *initially applying* for SSI benefits, and whose medical condition is such that there's a strong likelihood the person will be found eligible for disabled payments. The person must meet all nonmedical factors of eligibility—such as having low income and few assets. If you are an SSDI claimant—a worker who has paid Social Security taxes—you are not entitled to presumptive disability. If you apply simultaneously for SSI and SSDI, any presumptive disability you might qualify for will be based on the SSI claim only.



If you are only applying for SSDI benefits, you do not need to read this chapter. You may proceed to Chapter 5.

If the SSA agrees that you are presumptively disabled, you may receive payments for up to six months while your application for disability benefits is pending. Payments begin in the month in which the SSA made the presumptive disability finding. If, after six months of presumptive disability payments, the SSA has not made a formal determination on your disability application, the presumptive disability payments end until this formal determination is made.

People applying for SSI based on a disability are commonly awarded presumptive disability cash payments. It never hurts to request them. If you are granted presumptive disability, you can also receive free healthcare under Medicaid earlier than would otherwise be possible. But being granted presumptive disability does not necessarily mean that the SSA will make a favorable final determination on your disability application. And if the SSA denies your request for benefits before you have received a full six months of presumptive disability benefits, you will not receive the balance. You will not have to pay back any of the presumptive disability payments you were given before your claim was denied, except in two unusual situations (20 CFR § 416.537(b)1):

- The SSA later determines that you did not qualify under the nonmedical eligibility require-

ments—this exception primarily targets those people who commit fraud to obtain benefits.

- The SSA made an error in computing your monthly presumptive disability payment—in this situation, you need only repay the amount of money that went over the amount you were supposed to receive. Even in this situation, the SSA can waive the requirement that you repay the money if both of the following are true:
 - a. you were not at fault, and
 - b. repayment would defeat the purpose of the SSI law, would be unfair or would interfere with administration of SSI law due to the small amount of money involved.

NOTE: The sponsor of an alien who is denied disability may be responsible for repaying the alien's presumptive disability payments (20 CFR §416.550).

Emergency Payments

In cases of extreme hardship, the law permits a one-time emergency cash advance payment to people who appear to qualify for presumptive disability (42 U.S.C.A. § 1383(a)(4)(A); 20 CFR 416.520). Extreme hardship means that without the payment, you risk an immediate threat to your health or safety, such as the lack of food, clothing, shelter or medical care. This advance payment is not extra benefit money. The SSA eventually gets the money back, by deducting it from your presumptive disability checks, usually spread out over a period of six months. If you think you need an emergency advance payment, tell the Social Security Field Office when you are applying for SSI benefits. If you are eligible, you will receive an emergency payment, which will take seven to ten days to process. The amount of the payment for one person cannot exceed the federal benefit rate.

Emergency Versus Immediate Payments

Do not confuse *emergency payments* with *immediate payments*. The SSA will issue *immediate payments* through a Field Office in critical cases within 24 hours. These payments can be made to both SSI and SSDI claimants who qualify. To qualify, you must have a financial emergency or present a potential public relations problem for the SSA. You must already be receiving SSI or SSDI payments, so immediate payments do not apply to presumptive disability. Critical cases are those involving delayed or interrupted benefit payments. Examples might include the loss of a benefit check in the mail or a natural disaster like a hurricane or tornado wiping out parts of a town and interfering with normal benefit check delivery to a number of people. The maximum amount payable for either SSI or SSDI is \$999.

who are obviously disabled. This is one way the SSA is trying to speed up providing low-income disabled people financial assistance.

There are three ways presumptive disability by the Field Office can be given: based on the representative's observations, the statements of you or your guardian or after requesting verification from another source.

1. Observation

Under federal regulations, the Field Office representative can award presumptive disability upon seeing that a claimant has one of the following disabling conditions:

- amputation of two limbs, or
- amputation of a leg at the hip.

2. Statement by the Claimant or Guardian

The Field Office representative can award presumptive disability based on the word of the claimant (or the claimant's guardian, in the case of a child) that he has certain disabling impairments. The disabling impairments must be very severe, because the Field Office personnel are not doctors and are screening only for obvious cases. Note that the actual medical severity needed to ultimately qualify for disability based on one of these disorders may be less than what is required for presumptive disability. The conditions are as follows:

- total blindness
- total deafness
- bed confinement or immobility without a wheelchair, walker or crutches due to a long-standing condition—such as a chronic condition that is not likely to improve with further treatment and has been present for a year or more
- a stroke more than three months in the past with continued marked difficulty in walking or using a hand or arm—marked means more than moderate, but less than extreme, but does not require an inability to walk or total paralysis in an arm
- diabetes with an amputation of a foot

A. Applying for Presumptive Disability

You apply for presumptive disability at your local SSA Field Office when you apply for SSI. The SSA can grant presumptive disability at that time if you have any of a limited number of impairments (see Section B, below). Most applications are forwarded to the state Disability Determination Services (DDS) without an award of presumptive disability. But the DDS also has wide discretion to grant PD. So even if your condition isn't listed below, once your file is forwarded to the DDS, be sure to ask the examiner handling your claim about presumptive disability (see Section C).

B. Impairments Qualifying for Presumptive Disability by Field Office

An SSA Field Office representative has the power to grant six months of presumptive disability payments when you apply if there is a reasonable basis for believing that you have a disabling impairment. Of course, Field Office representatives are not doctors, but they can award presumptive disability to claimants

- cerebral palsy, muscular dystrophy or muscle atrophy along with marked difficulty in walking without using braces, in speaking or in coordination of the hands or arms
- Down syndrome characterized by mental retardation, abnormal development of the skull, short arms and legs, and hands and feet that tend to be broad and flat, and
- severe mental retardation in someone who is at least seven years of age—severe means the person depends on others for meeting personal care needs and in doing other routine daily activities.



Saying you're disabled isn't enough. A statement by a claimant or guardian that the claimant is disabled won't establish presumptive disability if the SSA Field Office representative believes the allegation may be false based on personal observation. For example, if a claimant alleges total blindness but the Field Office representative sees her reading a book, the SSA will not grant presumptive disability at the time of the application.

3. Disorders Requiring Confirmation

With certain impairments, the Field Office may need to confirm the claimant's allegation before granting presumptive disability. This situation arises when the alleged impairment is not observable by the Field Office representative or when the representative's observations are inconsistent with the allegations.

These conditions are as follows:

- human immunodeficiency virus (HIV) infection
- hospice services for terminal cancer
- a child six months or younger with a birth weight below 1,200 grams (2 pounds, 10 ounces), and
- a child six months or younger with a gestational age at birth corresponding to the birth weight indicated:

Gestational Age (in weeks)	Weight at Birth
37–40	under 2,000 grams (4 pounds, 6 ounces)
36	1,875 grams or less (4 pounds, 2 ounces)
35	1,700 grams or less (3 pounds, 12 ounces)
34	1,325 grams or less (3 pounds, 5 ounces)
33	500 grams or less (2 pounds, 15 ounces)

To confirm allegations for presumptive disability (except for HIV infection, see sidebar below), the Field Office representative must:

- record the information given by the claimant on a Report of Contact (RC) form, which is placed in the claimant's file
- explain the presumptive disability procedures to the claimant, and the need to contact a source to verify the allegation in order to make a presumptive disability finding
- ask the claimant or guardian for the name and telephone number of a reliable source who can verify the allegation. An appropriate source might include school personnel, a social service agency worker, a member of the clergy or other member of the community who knows of your condition based on frequent contacts and/or a long-term association with you.
- contact an appropriate source to determine if the claimant meets the presumptive disability criterion
- record the information obtained from the source on the RC form in the claimant's file, and
- inform that claimant.

Special Confirmation Needed With HIV Infection

If a claimant alleges HIV infection, including AIDS, the Field Office must send the claimant's treating doctor a form requesting information about the severity of the infection. The medical severity required for presumptive disability is like that described in the Listing of Impairments that deals with HIV infection. (See Chapter 29.)

C. Qualifying for Presumptive Disability Through the DDS

Once the SSA determines you are legally entitled to benefits, it leaves the initial determination of medical eligibility to a state agency called the Disability Determination Service, or DDS. If you fail to win presumptive benefits during the initial application process with the SSA, you can try again at the DDS. A DDS representative has much wider discretion in granting presumptive disability than a Field Office representative. The DDS determinations fall into three general categories.

1. High Potential for Presumptive Disability

The DDS is most likely to grant presumptive disability for the following disabilities:

- mental retardation
- cancer

- central nervous system diseases resulting in paralysis or difficulty in walking or using hands and arms
- irreversible kidney disease, and
- HIV infection.

2. Caution in Granting PD

The DDS uses caution in granting PD in the following disabilities because of the difficulty in predicting severity or duration of the impairment:

- diabetes
- epilepsy
- high blood pressure
- heart disease caused by high blood pressure
- peptic ulcer
- cirrhosis of the liver, and
- bone fractures.

3. Low Potential for PD

The DDS rarely authorizes presumptive disability payments for the following disorders:

- mental impairments, with the exceptions of mental retardation or where there is convincing evidence of prolonged severe psychosis or chronic brain syndrome
- breathing disorders, because tests of breathing ability are crucial to a determination of disability for most respiratory impairments, and
- back conditions, except in cases involving traumatic injury to the spinal cord. ■

Chapter 5

Proving You Are Disabled

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Every person who files a disability claim for SSDI or SSI is responsible for providing medical evidence to the Social Security Administration (SSA) showing that she is impaired. You do not have to physically provide medical reports to the SSA. If you give your permission, the SSA will help you get reports from medical sources that have treated or evaluated you.

Once you have established the existence of an impairment, the SSA considers both medical and non-medical evidence to assess the severity of your impairment. For this, the SSA requests copies of medical evidence from hospitals, clinics or other health facilities where you have been treated—if the SSA doesn't already have those records.

A. Acceptable Medical Sources

When considering both the existence and severity of your impairment, the SSA evaluates reports from all medical providers who have treated you, called your treating sources. These include doctors, chiropractors, naturopaths and other alternative providers. But to make an actual medical diagnosis and obtain medical information necessary for accurate disability determination, the SSA must have medical information from what it calls acceptable medical sources. Reports from these sources enhance the credibility of your claim of disability at the SSA.

EXAMPLE: You apply for disability benefits, but your only treating source for your back pain is your chiropractor. Any information provided to the SSA by that chiropractor, no matter how detailed, is not sufficient for the SSA to make a disability determination. You will be sent to an acceptable medical source for an examination of your back complaints.

Only the following are considered acceptable medical sources:

- **Licensed physicians.** A licensed physician holds an M.D. degree with a valid license to practice medicine in the state in which he or she practices.

Chiropractic, homeopathic, naturopathic and other alternative providers do not qualify.

- **Licensed osteopaths.** A licensed osteopath holds a D.O. degree with a valid license in the state in which he or she practices.
- **Licensed or certified psychologists.** A licensed or certified psychologist holds a doctorate degree (Ph.D.) in psychology. For the purpose of establishing mental retardation or learning disabilities, a licensed or certified psychologist includes a school psychologist or another licensed or certified individual with a different title who performs the function of a school psychologist in a school setting. Psychologists must be licensed in the state in which they practice.
- **Licensed optometrists.** An optometrist holds an O.D. degree. An optometrist is an acceptable medical source only for the measurement of visual acuity and visual fields. Even then, the optometrist's measurement must be combined with data from a medical doctor or osteopath who diagnoses eye disease. Optometrists must be validly licensed in the state in which they practice. Medical doctors (M.D.) or osteopaths (D.O.) who specialize in the treatment of disease of the eye are called ophthalmologists, and should not be confused with optometrists.
- **Licensed podiatrists.** A licensed podiatrist holds a D.P.M. degree and is validly licensed in the state in which he or she practices. Podiatrists are an acceptable medical source only to establish impairments of the foot—or foot and ankle, depending on the laws of the state in which they practice.
- **Speech-language pathologists.** A qualified speech-language pathologist is fully certified by the state education agency in the state in which he or she practices, is licensed by the state professional licensing board or holds a Certificate of Clinical Competence from the American Speech-Language-Hearing Association. A speech-language pathologist is an acceptable medical source only to establish speech or language impairments.

B. Medical Evidence From Treating Sources

Many disability claims are decided on the basis of medical evidence from treating sources that are also acceptable medical sources. For example, the doctor who treats you for high blood pressure is often the best medical source of information. SSA regulations place special emphasis on evidence from treating sources—especially if they are acceptable medical sources—because they are likely to provide the most detailed and long-term picture of your impairment. They may also bring a perspective to the medical evidence that cannot be obtained from the medical findings alone or from reports of examinations or brief hospitalizations.

1. Timely, Accurate and Sufficient Medical Records

Timely, accurate and sufficient records from your treating sources can greatly reduce or eliminate the need for the SSA to obtain additional medical evidence, which means you can get a faster determination on your disability claim. Timely, accurate and sufficient mean the following:

- **Timely** records are recent enough to be relevant to your current medical condition. How recent is a matter of medical judgment, depending on the disorder. A condition that is rapidly changing requires more up-to-date information than one that is slowly progressive or unchanged for years. Generally, the SSA likes to have records no older than six months. That doesn't mean older records aren't important. Records dating back for many years may help provide the medical big picture.
- **Accurate** records correctly describe your condition according to the standards of acceptable medical sources. To use a common example, a chiropractor can describe subluxation (slippage) of your spine on x-rays, but this will not be considered accurate if an acceptable medical source (see Section A, above) reports normal x-rays. Also, acceptable medical sources must report

their own information accurately. For instance, a treating medical doctor's records that say you can't walk one block because of chest pain will be rejected if specific exercise testing shows that you can do much more exercise.

- **Sufficient** medical records contain enough accurate information from acceptable medical sources to allow the SSA to make an independent medical judgment regarding the nature and severity of your medical condition. For example, an allegation and diagnosis of cancer is not sufficient. The SSA will want to know: Did a biopsy prove the cancer's presence? What kind? Where in the body? When did symptoms appear? What did a physical examination show? What did x-rays and other imaging tests show? What did blood tests show? Did you have surgery? Did it remove all of the cancer? Did you have chemotherapy? What side effects did you suffer, if any? Did you have radiation therapy? What were the results?

It is not enough for your doctor to start keeping detailed records when you apply for disability.

EXAMPLE: You were sick for six months before you applied for disability and were unable to work during that time. You might be eligible for a retroactive award of benefits for the six months you couldn't work. But if your doctor does not have detailed medical records for the entire period he has been seeing you, you might not be able to prove you were unable to work during those six months. There is no way for your doctor to believably recreate detailed medical records from memory. If he remembers something not in his written records, the SSA will evaluate such statements on a case-by-case basis. For example, if your doctor remembers that you have always had pain in the joints of your hands, that is more believable than remembering that you had 10° of motion in the second joint of your left little finger three years ago. In all instances, however, the SSA knows that memory is not as reliable as written records.

2. Thorough Medical Records

The medical records of a treating source are of critical importance to a disability claim. Luckily, doctors usually write things down about their patients and their treatment—and patients expect their doctors to remember them and their conditions. But not all doctors record complaints, diagnoses and treatments with the same detail. A doctor can see as many as 30 or 40 patients a day. Even if your doctor sees only 20 people in a day, your doctor may have seen, evaluated and treated as many as 400 patients from the time of your first visit to your next one a month later. You might not even see the same doctor on each visit, depending on your healthcare provider. Unless your doctors keep good medical records in writing, you cannot reasonably expect them to have an adequate knowledge of your condition.

Medical consultants working for the SSA and in a DDS see the records kept by thousands of doctors on their patients. The quality of these records varies greatly. Some are typed, mention all of the patient's complaints, show the results of examination, note what treatment was given, state the response to treatment and mention future plans. Many records are unreadable, however, or don't contain enough information to determine disability.

EXAMPLE: Many people apply for disability benefits based on their arthritis. When the disability examiners review the records provided by the treating doctor, often the file contains a few scribbles that the patient has joint pains and arthritis, and further notes that some form of treatment has been given. Often, medical records contain no description of diseased joints, no range of motion test results and no x-rays. The SSA spends extensive time and money each year obtaining data from joint examinations, x-rays and other lab tests.

The SSA cannot evaluate medical records that are scribbled and unreadable, nor can they evaluate medical records that lack significant information about your condition. If your files are incomplete, however,

understand that it is not because of any malice on the part of your doctor. Doctors don't routinely document their files for disability purposes. Their records are to help them treat their patients. On the other hand, the SSA often sees treating doctor records that are of poor quality, either for treatment or disability determination purposes.

EXAMPLE: To qualify for disability based on epilepsy, you must have had a certain number of seizures during a specified time period. But physicians—even neurologists who specialize in treating epileptics—often do not record the number of seizures a patient has had between visits, even though they should in the event an adjustment of medication might be needed. Nor do physicians usually describe a seizure in detail in their records, though they will note the type of seizure involved and drugs given. The SSA requires a number of other things to evaluate the severity of epilepsy, such as whether or not you cooperate in taking medication and the blood levels of drugs used to treat the epilepsy. These are often missing from a treating doctor's file.

3. Obtaining Records From Your Treating Doctor

You need to make sure the records your doctor keeps on your health are thorough enough to prove your case to the SSA. If they are not, you must augment the information they contain. It will also speed up the disability determination process if you can deliver your records to the SSA—either when you make your application or later to the claims examiner at the DDS.

Many doctors consider medical records their property, even though they record your health history; in rare instances, they might be reluctant to give you copies. Laws vary across the country on a doctor's obligation to hand over your medical records. The best approach is to ask politely for them. For most people, a call to the doctor's office explaining you are applying for disability is sufficient.

Releasing Records for Mental Disorders

Psychiatrists and psychologists are more likely to release records to the SSA than to patients. Some won't even release records to the SSA. These records may contain comments about a claimant's mental disorder that could harm the doctor-patient relationship or the claimant's relationship with other people.

One simple way to avoid this problem is to talk with your treating professional about writing a summary of their findings on your mental condition only as it relates to your disability claim.

This summary should contain detailed comments about the kind of information the SSA wants in evaluating a mental disorder (see Chapter 27), while omitting personal information irrelevant to the disability determination. In fact, this might be the preferable solution if you have voluminous records.

Your treating professional must review the listing requirements of your disability in the SSA listings of impairments. A summary or letter that does not address the requirements of a listing will do little or no good to your claim.

If your treating doctor is hesitant to let you have copies of your records, don't just say, "Thanks a lot" and hang up. Explain again that you need to see your records for your disability claim and ask why you can't have a copy. If you are dealing with resistant office personnel who simply say it is an office policy, ask to speak with the doctor. If you get a runaround on talking to the doctor, write a letter explaining why you want your records. Write "personal and confidential" on the envelope to make sure the doctor gets the letter.

If your doctor still refuses to let you have a copy of your file, won't answer your questions regarding your medical conditions, gives you rude answers, treats you like an idiot, has a cold demeanor or has little time for you, then you should consider finding a new treating doctor. An uncooperative doctor probably won't cooperate with the SSA on your behalf anyway. The SSA cannot force a doctor or hospital to turn over

medical records, and it is not unusual for the SSA to wait months to receive medical records from treating doctors. If you are really determined to get records from an uncooperative doctor, you may need the services of an attorney who may be able to force the doctor to turn over your records. However, that would be an expensive option. Fortunately, most doctors will give you a copy of your records simply for the asking.

4. Obtaining Records From Hospitals and Medical Centers

Like most treating doctors, most hospitals and medical centers will let you have copies of your records without any problem. Just call the hospital and say you want a copy of your medical records; you don't have to ask your doctor's permission.

Note that some hospitals charge high per-page copy fees to former patients—as high as a dollar a page! It is not reasonable to have to pay such a high fee when copying costs only a few cents per page. If a hospital can provide copies of records to the SSA for a small fee, there is no reason they should charge a private citizen a large fee. So express mild outrage at the fee and tell the hospital you know they make records available to the SSA for a small fee.

If the hospital still refuses, you can call the social services department of the facility and ask them for help. You can also look for free legal aid clinics in your area that may be able to negotiate on your behalf. Of course, you can also wait until the hospital sends the records to the SSA and review them when they are in your file. But hospitals are often slow in sending files to the SSA.

It is important for you to review hospital records being used to determine your eligibility for disability. Some of the information may be incorrect. It is common for doctors of hospitalized patients to focus on the immediate cause of admittance to the hospital and ignore other problems. For example, a doctor examining a patient for a heart problem may report that all other areas of the body are normal, even if they have not done a complete physical examination.

Such a practice is not uncommon, even with patients the doctor has never seen before. This can lead to serious errors and conflicts in your medical records. Doctors often do this to cut corners while satisfying hospital rules that require complete exams of hospitalized patients.

You should ask yourself: Did the doctor really examine all parts of your body they reported as normal? Did the surgeon who did your abdominal surgery really look in your eyes, ears, nose and throat? Did they really check your reflexes and your skin sensation? Examine your joints for arthritis? If you were hospitalized for a heart attack, did the cardiologist look at anything but your heart and lungs before dictating an otherwise normal physical examination into hospital records?

Doctors tend to concentrate on their areas of specialty, but when they report “normal” for the other areas they didn’t examine it can be a real problem for you in establishing disability. If you find that this has happened in your case, make sure that you call or write to the SSA and tell them that various parts of your body were not actually examined and are not normal. In these instances, the SSA should arrange for an independent consultative examination.

5. If Your Records Are Insufficient

Once you see your medical records, you may be concerned that they are insufficient for Social Security purposes (see Sections 6 and 7 below for information on what is needed in your medical records). Don’t necessarily blame your doctor. The files of many treating doctors are incomplete from the point of view of the SSA, but contain a perfectly reasonable amount of information to treat their patients. Furthermore, your medical file might omit certain symptoms or conditions simply because you forgot to tell your doctor about them.

Doctors are often bogged down with paperwork: insurance companies, workers’ compensation programs, employers, government agencies, lawyers, patients and other physicians all request written information from doctors. Few doctors enjoy tasks that take them

away from seeing patients. Your doctor may never have thought about the kind of evidence the SSA needs. Let your doctor know that to support your claim of disability, the SSA will require specific medical evidence about your impairments and how your impairment affects your day-to-day functioning—not merely a letter stating that you are disabled. If your doctor sends the SSA a brief letter and no other medical information, you will be required to undergo an examination paid for by the SSA.

If your doctor insists on sending a letter to the SSA, let her know that it must contain extensive detail about your impairment and how it affects your ability to function—including your ability to walk, breathe or use your hands and arms. Don’t assume that your doctor knows all of your impairments and how they limit your daily activities. Make sure your doctor knows your limitations.

Some doctors are willing to simply write that you are “permanently and totally disabled,” even if you don’t have that much wrong with you. They want to please their patients. But federal law requires that your SSA file contain actual objective evidence showing how your impairments limit your ability to function.

Your doctor doesn’t have to become an expert in job performance. But it will help your case enormously if he provides evidence of your physical or mental medical disorders. Your doctor may be inclined to write the SSA, saying that you cannot work at all. Although this may be well intended, your doctor is not a vocational counselor. The SSA has vocational specialists who determine what jobs can be done with various impairments. Many people are capable of some kind of work, even though their doctor thinks the medical evidence shows them to be disabled. Many people who qualify for disability benefits do so because of both nonmedical (age, education and work experience) and medical factors. The SSA ultimately determines whether or not you are disabled—that is, whether or not you can work given your particular impairments.

Most people applying for disability would be granted benefits if it were up to their treating doctors. Doctors want to help and maintain a good relationship with their patients. But their opinions about their

patients and their patients' claims are far from unbiased. Even if those doctors could give neutral opinions, they shouldn't make the final disability determination. Doctors would become the targets of irate disability advocate organizations, and the subject of lawsuits and political scrutiny. This is the role of the government, not the medical profession.

Nevertheless, your doctor can have much influence on the ultimate outcome of your claim for disability by providing ample medical information about your impairments.



Chapters 16 through 29 provide details on what constitutes a disability for purposes of SSDI and SSI. If your doctor needs help determining what kind of evidence the SSA will need, those chapters can help. In addition, Section D, below, includes information related to symptoms.

6. Evidence the SSA Needs From Treating Sources

In general, here is the basic evidence the SSA needs:

- your medical history
- clinical findings, including the results of physical or mental status examinations
- laboratory findings, such as the results of blood pressure tests or x-rays
- your doctor's diagnosis of your condition
- your doctor's prescribed treatment, as well as your response to that treatment and your doctor's prognosis—that is, the prospect for your recovery from a medical condition, and
- your doctor's opinion about what you can do despite your impairments, based on the medical findings. This statement should describe your ability to perform work-related activities, such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking and traveling. In cases involving mental impairments, the statement should describe your ability to understand, carry out and remember instructions, and to respond

appropriately to supervision, coworkers and work pressures. For a child, the statement should describe the child's ability to function effectively in a manner appropriate for his or her age. If you are legally blind (vision worse than 20/200 best corrected in both eyes or visual fields 20 degrees or less), you'll be granted benefits and your doctor need not describe your ability to perform the above activities.

Keep in mind that your claim could be denied no matter how much information your doctor provides if you don't fit the criteria for disability or you are found ineligible based on nonmedical reasons. If you are denied benefits, the SSA will tell you the reasons for denial. (See Chapter 12 for more on appealing a denial from the SSA.)

7. Treating Source Statements and Medical Assessments About Your Ability to Function

If your treating doctor gives a medical opinion about your ability to function, the SSA *must* take that opinion into account. These opinions are called *treating source statements*. The DDS, which evaluates your condition for the SSA, is supposed to ask your treating doctors for such statements when it asks for your medical records.

However, most treating doctors do not give this type of opinion, even when asked by the DDS. Your doctor may not either, for any number of reasons. He may not see the request because his office staff sends the SSA your records, he may feel he does not know enough about your condition to have an opinion on disability determination or he may feel that the SSA bureaucracy will not pay attention to his opinion. Because your treating doctor's opinion about your abilities and limitations actually *is* important, consider contacting him to ask him to make a statement for you. Of course, you don't want to do this if your treating doctor is of the opinion that you can do more than you actually can.

The Weight of Your Treating Doctor's Opinion

Federal regulations require the SSA to accept your treating doctor's assessment unless the SSA's own decision maker (such as a DDS medical consultant or administrative law judge on appeal cases) can give a reasonable explanation for rejecting it. Specific information about your condition from your treating doctor will be given greater weight than the opinion of other doctors who may have seen you only once—be they doctors who examine you for the DDS or even a specialist.

Medical assessments offered by your treating doctor have little weight, however, when not supported by evidence. For example, if your doctor says you can't lift more than ten pounds but doesn't say why, that opinion is worth nothing. If she says you can't lift more than ten pounds because of arthritis in your hands, the opinion has little weight without evidence of activity-limiting arthritis. If she says you can't lift more than ten pounds because of arthritis, describes your physical abnormalities and provides x-ray reports showing the arthritis, her opinion will be considered quite strong.

C. The Role of Consultative Examinations in Disability Determination

If the evidence provided by your treating doctor and other medical sources is inadequate to determine if you are disabled, the SSA may seek additional medical information, called a *consultative examination* (CE).

1. Who Performs Consultative Examinations?

If your treating doctor has the necessary skills, the SSA prefers that he or she administer the CE. But few doctors are willing to administer CEs to their own

patients on behalf of the SSA. That's because it could strain relations between the doctor and patient if the SSA denies a disability claim based on the CE.

2. If Your Treating Doctor Refuses to Perform the Consultative Examination

If your treating doctor refuses to administer the CE, the SSA will arrange it with an independent doctor. Even if your doctor is willing to administer your CE, the SSA can send you to a different CE doctor if any of the following are true:

- Your doctor does not have the equipment to provide the specific data needed.
- Conflicts or inconsistencies in your medical file will not be resolved by using your doctor.
- You prefer that someone other than your doctor administer the CE and you have a good reason for wanting it—for example, you don't want to compromise your relationship with your doctor.
- The SSA has prior experience with your doctor and does not believe that he or she will conduct a proper CE. This might happen, for example, if the DDS knows from past experience that your treating doctor does a poor job in conducting CEs. In other instances, treating doctors do adequate CE examinations, but are so slow sending the results to the DDS that a case can be held up for many unnecessary months.

3. Who Pays for the Consultative Examination?

The SSA pays for all CE examinations and reports—even if your own treating doctor administers the CE. Consultative examination doctors cannot decide whether or not you qualify for disability. Their assessments can be useful, but usually do not carry the weight of your treating doctor's medical assessments supported by evidence.

Consultative Examiners Versus Medical Consultants

Doctors who do CEs for the SSA are not the same as DDS medical consultants. This can be confusing, because CE doctors may also be consultants for the DDS. When they are performing work for the DDS, they are called “DDS medical consultants.” Here is the difference. CE doctors examine claimants and send their reports to the SSA with an opinion on what a claimant can do, given the claimant’s medical condition. CEs do not necessarily have the training or authority to make a medical disability determination. On the other hand, DDS medical consultants do not actually examine claimants, but do have the authority to make disability determinations based on the special training by the SSA/DDS that they must undergo before being allowed to make decisions, as well as ongoing training they receive. However, some DDS medical consultants are less knowledgeable about the Social Security disability program than others, because of lack of personal motivation or only part-time work for the DDS.

4. How Common Are Consultative Examinations?

A significant percentage of disability claims involve the use of CEs. The SSA spends many millions of dollars on CEs every year. The SSA must order a large number of CEs for several reasons:

- Many claimants don’t have treating doctors.
- Medical records from treating doctors may be too old.
- Claimants have complaints they never mentioned to their treating doctors.
- Some treating doctors refuse to provide records.
- Some treating doctors’ records aren’t useful for disability determination.

5. Contents of a CE Report

A complete CE is one in which the doctor administers all the elements of a standard examination required for the applicable medical condition. If you undergo a complete CE, the doctor’s report should include the following information:

- your chief complaints
- a detailed history of the chief complaints
- details of important findings, based on your history, examination and laboratory tests (such as blood tests and x-rays) as related to your main complaints. This should include abnormalities that you do have (positive findings such as swollen joints in physical disorders or presence of delusions in mental disorders), as well as abnormalities that didn’t show up during your exam (negative findings). Other abnormalities found during a physical exam or with laboratory testing should also be reported, even if you didn’t know of them or complain of them.
- the results of laboratory and other tests (such as x-rays or blood tests) performed according to the Listing of Impairments (see Chapter 7 and Chapters 16 through 29)
- the diagnosis and prognosis for your impairments, and
- a statement about what you can do despite your impairments; this is the same kind of information that the SSA requests from your treating doctor except that your treating doctor’s opinion generally carries more weight.

Many CEs arranged by the SSA are not complete physical or mental examinations, but are specific tests. For example, many claimants who complain of shortness of breath caused by lung damage from cigarette smoking are sent for breathing tests only; their treating doctors or a prior CE already provide the necessary physical examination data. Many claimants are sent for blood tests required by the Listing of Impairments, or that are otherwise necessary to determine a disability. X-rays are another kind of CE frequently performed without a full examination.

When the CE doctor administers only a specific test, he is not expected to provide an opinion regarding what you can do given your impairments.

6. Who Serves As Consultative Examiners?

All consultative examiners used by the SSA are acceptable medical sources (see Section A, above) in private practice, or associated with an acceptable medical source to perform a related test. For example, the SSA may have your hearing tested by an audiologist, as long as you are or have been examined by a physician. On the other hand, the SSA will never send you to a chiropractor, naturopath, herbalist or other alternative healer for an examination.

7. Your Protections in a Consultative Examination

It is the SSA's responsibility to make sure that consultative examiners provide professional and reasonable care. Examining rooms should be clean and adequately equipped and you should be treated with courtesy. The DDS is supposed to ask you questions about your CE—how long you had to wait, whether you were treated with courtesy, how long the examination took and whether it seemed complete. If you have a complaint about your CE experience and have not been asked about it by the DDS, call the public relations department at the DDS to voice your concern.

The SSA tries to screen out doctors who violate adequate standards for a CE or who provide incomplete or repeatedly inaccurate reports. Doctors may take shortcuts with a CE because the SSA doesn't pay much for them and doctors are often in a hurry. A nurse can record a part of your history as long as the doctor reads what the nurse wrote and reviews the important parts with you. But no one other than a doctor should examine you. If only a nurse or physician's assistant examines you and the doctor signs the report, the examination is not adequate.

The SSA provides CE doctors with detailed instructions regarding the requirements for an adequate and complete examination. These standards are generally accepted by the medical profession as needed for the competent examination of any patient in the specialty concerned.

EXAMPLE: You are sent to an arthritis specialist (rheumatologist) because you complained of joint and back pains. The doctor has her nurse take your history and spends ten minutes with you, looking briefly at some of your joints. The doctor does not test how well the joints move or how well you can walk. This inadequate exam will be unacceptable to the SSA.

8. If the Consultative Examination Is Inadequate

If you did not receive an adequate consultative examination—particularly if the doctor did not examine you about your complaint—contact the DDS examiner who arranged it. Call, but also send your complaint in writing to be added to your SSA file. If you have appealed your denial of disability and are at the administrative hearing level, complain to the administrative law judge. Tell the DDS examiner or judge about the inadequate examination and ask to be sent to someone who will examine you properly. If your complaint is not taken seriously, write to the DDS public relations department and the DDS director. If that doesn't work, call the SSA's hotline number (800-771-2123) and ask for assistance.

D. Evidence of Symptoms

The SSA will investigate many areas of your life and the effect of symptoms—such as pain, shortness of breath or fatigue—on your ability to function.

1. Evidence Related to Symptoms

Evidence of symptoms will include the following kinds of information provided by your treating doctor and other sources.

- **Your daily activities**—what you do during a typical day. Especially important is how these activities of daily living (called ADLs in SSA lingo) are affected by your pain and other symptoms.

- **The location, duration, frequency and intensity of the pain or other symptoms**—where you have pain or other symptoms, how long the symptoms last, how often the symptoms occur and the severity of the symptoms.
- **Precipitating and aggravating factors**—what activities or other factors are known to cause or exacerbate your symptoms.
- **The type, dosage, effectiveness and side effects of any medication**—whether prescribed or purchased over the counter, the dosage used, whether or not the medication helps pain or other symptoms and the type and severity of any side effects. Medications include herbal or other alternative medicine remedies. Be sure to let your treating doctor know if you are taking anything she hasn't prescribed.
- **Treatments, other than medications, for the relief of pain or other symptoms**—including things like hydrotherapy, music therapy, relaxation therapy, biofeedback, hypnosis, massage, physical therapy, transcutaneous electrical nerve stimulators and meditation.
- **Any measures you use or have used to relieve pain or other symptoms**—this information may offer the SSA insight into the nature and severity of your condition.
- **Other factors concerning your functional limitations due to pain or other symptoms.**



If you reveal to the SSA that you use marijuana, even if it is clearly for medical reasons, the SSA may be compelled by federal law to consider it a Drug Abuse or Alcoholism (DAA) problem that could affect the outcome of your disability determination. DAA is discussed in Chapter 11, Section F.

2. The SSA Evaluation of Symptoms

The SSA makes its determinations based on your individual symptoms, not a general perception. For instance, rarely would the SSA give any weight to your allegation of headaches, because in most people headaches are not frequent enough or severe enough to prevent work. But some people have severe,

frequent migraine headaches that last hours or even days at time, and which do not respond to treatment by doctors. It is rare to see headaches this severe, but if you have them, the SSA can use them to allow disability benefits. In the case of a disorder like headaches, where a physical examination shows very little abnormality, it is particularly critical that your treating doctor has good records about the severity, duration and frequency of the headaches. These records will provide credibility to your allegation that the headaches are disabling.

Almost all people who apply for disability have pain or other symptom complaints, such as dizziness, weakness, fatigue, nervousness or shortness of breath. Any DDS or SSA medical consultant or administrative law judge who does not ask about your symptoms or who does not take them into account is in violation of federal regulations.

Just because you say you have certain symptoms, you will not automatically be granted disability. Although the SSA must give consideration to your individual symptoms, the SSA is not obligated to believe that you have the symptoms you say you have or to believe that they are as severe as you say they are. Remember—an acceptable medical source must provide objective evidence that reasonably supports the severity of the symptoms you allege.

What you do regarding your symptoms is much more important than what you say. If you have back pain and have frequently seen doctors in an attempt to improve the pain, this indicates that you might really have severe back pain. But your statement about severe pain becomes less believable when you haven't seen a doctor. And if you have seen a doctor, then his evaluation and treatment are very important.

EXAMPLE 1: You have back pain. You have had multiple back surgeries to address what your doctor believes to be the abnormalities that cause the problem. But the pain has continued. Your doctor has given you injections of steroids in an attempt to block pain and you have used a TENS electrical stimulator unit for pain. You take pills for pain. When you say that you are highly

restricted in what you can do because of pain, the SSA should give considerable weight to your statements.

EXAMPLE 2: You have back pain. But you've never had surgery, have no abnormalities on physical examination and have normal x-rays of your back. When you say you can't do anything because of back pain, the SSA is not likely to believe you.

3. The SSA Evaluation of Pain

Pain and other symptoms often go to the heart of the restrictions on your activities of daily living. As explained in Chapter 2, you must complete forms describing what you do during an average day and what you cannot do. In back pain cases, it is important to measure how long you can sit and stand in one continuous period. Inability to sit or stand very long can be very critical to the outcome of your claim, if the SSA believes your symptoms. If your doctor writes the SSA about your back pain, make sure that he remarks on your ability to lift and bend (stoop). Your doctor should state how long he thinks you can stand and sit in one continuous period as well as the total time you can sit and stand during a typical work day.

4. If Physical Evidence Does Not Support Your Claim of Pain

If you allege that you have severe restrictions from pain, but no doctor (your own or a CE doctor) can find any reasonable physical basis for it, the SSA is likely to consider the possibility that you have a mental disorder of some kind.

EXAMPLE: You apply for disability and the evidence indicates there is very little wrong with you physically. But you say you must use crutches to walk or even use a wheelchair, and have been living

that way for some time. This suggests a mental disorder, and the SSA is likely to ask you to go to a mental examination by a clinical psychologist or psychiatrist.

In obvious cases of malingering (pretending an illness), the SSA would not request a mental examination. In fact, now and then a claimant will rent a wheelchair or crutches just for a CE, and is then seen by the doctor walking normally to a car after the exam. And most CE doctors can tell when there is no medical reason for a wheelchair, crutches or walker. In other words, attempted fraud when no condition exists is not likely to be successful. But claimants who have significant impairments may sometimes successfully exaggerate the severity of their conditions. Such dishonesty is difficult to detect, but is sometimes exposed when the SSA obtains treating doctor records showing less severity.

E. Other Evidence

Information from sources other than your treating physician and any consultative examiner may help show the extent to which your impairments affect your ability to function. Other sources include public and private social welfare agencies, teachers, day care providers, social workers, family members and other relatives, clergy, friends and employers and other practitioners such as physical therapists, audiologists, chiropractors and naturopaths.

If you want evidence from these types of individuals and practitioners, ask them to write a letter to be put in your file for the DDS to review. You may also mail in the records of any practitioner yourself or give them to the SSA Field Office representative when you file your claim.

The evidence will be given little weight in evaluating your claim, however, if it contradicts the evidence of acceptable medical sources described in Section A above or does not consist of evidence generally acceptable to the medical community.

The SSA Does Not Consider Nontraditional Treatments

The SSA will give little or no weight to unproven and unscientific medical conditions, tests and treatments involving things like iridology, colon therapy, detoxification schemes, megavitamin therapy, therapeutic touch, psychic diagnosis, rolfing, aromatherapy, ayurveda, juicing, acupuncture, homeopathy, faith healing, copper bracelets, magnet therapy, yeast allergy, Qigong, chelation therapy, applied kinesiology, reflexology, multiple chemical sensitivity (ecologic illness, environmental illness), provocation-neutralization tests and many others types of nontraditional therapy.

The SSA has no public list of unacceptable treatments and tests. However, a very valuable Internet site for studying the kinds of treatments and tests that you cannot expect the SSA to pay much attention to can be found at www.quackwatch.com. This site also contains a dictionary with over a thousand tests and treatments that you can't use to support a claim for disability. An-

other useful site is the National Council Against Health Fraud at www.ncahf.org. Federal government sites such as the Food and Drug Administration (www.fda.gov) and the Federal Trade Commission (www.ftc.gov) also have valuable advice and information for identifying bogus health schemes, treatments and tests.

You can also talk to a medical doctor about whether a given treatment or test is generally recognized by the medical community as valid, accurate or useful. Or, check medical dictionaries, authoritative medical textbooks such as those published by the American Medical Association and reputable medical Internet sites such as www.drkoop.com and www.ama-assn.org to see if there is any information on the treatment or test of interest to you. If not, it may be that the test or treatment has no real medical validity. You could even go to a medical school library (if one is nearby) and ask the librarian if there is any information on a particular test or treatment.



Chapter 6

Who Decides Your Claim?

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After the Social Security Administration Field Office finds that you meet the nonmedical eligibility requirements for disability benefits, your file is sent to the state agency responsible for making a decision on your application. This agency is known as the Disability Determination Services, or DDS. Your file will contain your application, the few administrative documents you completed at the SSA Field Office and copies of any medical records or other relevant papers you provided the SSA when you applied.

A. DDS Basics

DDS offices are run by each state, but they are federally funded, and must follow the federal laws and regulations. Each DDS has a computer system connected to the SSA federal computers in Baltimore and to the local SSA Field Offices. These computers allow the DDS and the SSA to quickly communicate.

1. Types of Claims Handled by DDS

The DDS handles several types of disability claims, including:

- a new application, called an *initial* claim
- a *reconsideration claim*, if you are turned down
- another *initial claim*—in fact, you can file as many initial claims as you want, and
- *continuing disability review* claims, which are periodic reviews by the DDS of the files of disability recipients to see if their health has improved.

2. When the Outcome of a Claim Is Uncertain

If you apply for disability when you are acutely sick or hurt and the outcome of your treatment is not clear, the DDS may *diary* your claim. This means that the DDS holds your file to see how your illness or injury progresses to see if you will have an ongoing or permanent disability. Diaries usually last up to three months, but can sometimes last as many as six. Heart impairment claims often require diaries because

claimants apply for disability soon after they've had a heart attack or heart surgery, and the outcome of their treatment is unknown. Other claimants who might need a diary include people who apply soon after incurring multiple serious fractures in an automobile wreck or soon after incurring a brain injury.

B. DDS Claims Examiners

When the DDS receives your file, it assigns a claims examiner to your case. The examiner's job is to obtain the medical records listed on your application, maintain contact with you and do other administrative work as necessary. Claims examiners are your point of contact with the DDS. Your DDS will have a toll-free telephone number you can use from anywhere in your state. If you don't have this number, check the government section of your phone book, call the SSA Field Office where you made your application, call the general number for the SSA, 800-772-1213, or check the SSA website at www.ssa.gov.

There are various types of examiners: those who handle initial claims, those who do reconsideration claims, those in the quality assurance department who review the work of other examiners and those who evaluate people already receiving benefits to see if they still qualify.

It's important that you understand the job of the examiner and the kinds of work pressure she is under. A DDS examiner is responsible for evaluating the nonmedical aspects of your claim—other than nonmedical eligibility issues that were already handled by the SSA Field Office. The number of nonmedical issues potentially involved in a claim is so large that it is impossible to list them here. But they do include:

- deciding the date you actually stopped work for disability purposes
- finding your vocational factors, including age, education and work experience
- arranging for consultative examinations and coordinating your attendance
- contacting your treating sources for your medical records, and
- asking DDS medical consultants for advice on the nature and severity of medical impairments as well as what kind of additional medical evidence is needed to decide your claim.

How Claims Examiners Think

Claims examiners sometimes are taught about basic medical principles by the DDS medical consultants. This is to help them better understand the medical issues involved in claims, but does not qualify them to make determinations about the medical severity of your impairments. Unfortunately, this doesn't stop some examiners from trying. Under current regulations, however, examiners cannot make medical determinations, except in some pilot studies involving redesign of the Social Security disability evaluation process. (See Section H, below.)

As might be expected, claims examiners vary greatly in their intelligence and motivation. Some meticulously consider and document every detail. Others care only about processing claims as fast as they can with the least amount of work. DDS offices have internal quality assurance reviews that are supposed to catch poor work. Examiners have supervisors who are supposed to monitor their work. But supervisors also vary in how conscientious they are and in their willingness to make sure their examiners are doing good work. In addition, a DDS may not conduct the number of internal quality assurance reviews called for. This raises the likelihood of claims being done incorrectly and escaping the agency undetected.

If a DDS is understaffed and underfunded, the number of cases an examiner has to handle increases. If your

examiner has a caseload in the hundreds, the probability of errors increases greatly.

The more you know about the disability determination process, the more likely you will be able to spot an examiner who improperly handles your claim or an issue in your file that was decided wrongly.

Here are some hints. Watch out if:

- You know a decision was made without sufficient medical information. For example, the DDS denies your claim for a vision problem without requesting and reviewing your treating doctor's records or sending you for a consultative examination of your eyes. It is illegal for a DDS to ignore all of your medical allegations.
- The examiner or their supervisor appears evasive or unable to answer your questions on the telephone.
- An examiner or supervisor says they will call you back to answer a question and fails to do so.
- The examiner or their supervisor says they don't need to take your claim to a DDS medical consultant for an evaluation of your medical records, or won't tell you if they are going to ask a doctor to look at your records. It is a violation of federal regulations for an examiner to make a medical determination of disability or to determine your residual functional capacity (see Chapter 8). But it happens.

In fact, examiners have difficulty keeping up with the endless, changing rules. They refer to a huge, multivolume publication called the *Program Operations Manual System (POMS)*. If the POMS does not have the answer to a question, the examiners ask their immediate supervisor, who can ask higher supervisors. If the DDS personnel don't know the answer, they send the question to the SSA Regional Office.

C. Other DDS Administrative Personnel

DDS offices have administrative personnel besides claims examiners. Claims examiners are usually arranged

into units, each with a supervisor and perhaps an assistant supervisor. The supervisors in turn answer to their supervisor—usually an operations manager, quality assurance manager or assistant director. The position titles may vary, but the general idea is that there is a bureaucracy with many levels of authority.

You would ordinarily only meet your examiner and, in many cases, even that contact would be limited to the telephone. A vocational analyst (see below) could also call you to discuss specific issues about the work you did or your education. You can also demand to speak to an examiner's immediate supervisor. You would not routinely come into contact with higher level personnel, but it is possible. Claimants who are

angry about their treatment and not satisfied by the supervisor could be referred to an assistant director. Other claimants don't wait for referral up through the chain of command—they call the DDS director out of their own initiative.

The DDS director may be appointed by a state governor, which could mean frequent turnover. The agency director sets the tone of the agency. How a particular agency runs, therefore, depends on the director's integrity, intelligence, dedication, managerial ability, motivation and desire to provide good public service. Agency directors do not have the legal authority to make the medical part of disability determinations—only an SSA medical consultant or disability hearing officer can do that.

The other administrative personnel at a DDS you might encounter include secretaries and vocational analysts. Vocational analysts are specially trained examiners who assess your ability to work based on the severity of your medical impairments, your work experience and your education. Vocational analysts are often assistant supervisors of a group of examiners.

D. Medical Consultants

Medical consultants are the people who ultimately review the medical aspect of your claim for disability benefits. A medical consultant must be a licensed medical doctor, osteopath or psychologist with a Ph.D. If you apply for disability based on physical impairments, a medical doctor or osteopath will evaluate your file. If you apply for disability based on a mental impairment, a psychiatrist (either a medical doctor or osteopath) or a qualified psychologist will evaluate your file.

If you apply for disability based on both a physical and a mental impairment, a psychologist can evaluate only the mental impairment. A medical doctor or osteopath must evaluate the nonmental impairment. The overall determination of disability must be made by a medical doctor or osteopath unless the mental impairment alone would justify a finding of disability.

1. The Medical Consultant's Job

A medical consultant's work is performed mostly at a desk, in an office. It is strictly a paper review; the physician or psychologist usually has no contact with you. The work of determining whether or not you qualify for disability includes the following:

- evaluating medical evidence to determine if your impairment meets the requirements of the Listing of Impairments (see Chapter 5, Section D1)
- assessing the severity of your impairments and describing your remaining physical or mental abilities (called the residual functional capacity or RFC) or limitations in abilities that are caused by the impairments (see Chapter 8)
- discussing with DDS other ways to get medical evidence, including suggesting ways to improve communication between the DDS and treating sources. For example, the medical records department of a hospital might tell a claims examiner that it doesn't have a biopsy report showing that you have cancer. The medical consultant can suggest that the examiner call the pathology department of the hospital. Or a claims examiner might not be able to get your treating doctor on the telephone to ask questions about impairments that were not covered in your doctor's medical records. A medical consultant, as a doctor, has a better chance of getting a treating doctor on the telephone. Because of time constraints, however, medical consultants do not usually talk to the treating doctor.
- evaluating medical questions asked by a claims examiner. For example, a claims examiner may need to know whether it is reasonable to award an SSI claimant presumptive disability. Or a claims examiner may need to know the probability of a medical condition improving in order to schedule a re-review of the file. Or a claims examiner may need to know exactly what medical records are needed. The medical consultant would answer these questions.
- reviewing requests for consultative examinations (CEs) to make sure they are necessary and will address the issue in question

- suggesting alternatives when you cannot or will not attend a CE, or cannot or will not cooperate with disability determination in other ways. For example, some claimants refuse to attend a CE, feeling that their treating doctor has the information. If the treating doctor has not provided the DDS with the information, the medical consultant can suggest that the claimant visit his doctor and personally obtain the records. On the other hand, if the claimant won't attend a CE because she has agoraphobia—a fear of leaving her house—the medical consultant can intervene to have a psychologist or psychiatrist sent to the claimant's home.
- reviewing consultative reports that don't give enough medical information for a disability determination and recommending to the CE doctor ways to avoid deficient reports
- participating in the vocational rehabilitation screening and referral process, by advising whether you are medically capable of undergoing training for new job skills
- reviewing disability determinations to assure that the decision is based on medical evidence, and
- signing disability determination forms.

If a Medical Consultant Gives Medical Evidence

If a medical consultant furnishes any of the medical evidence for a particular disability case, he should disqualify himself from determining disability—that is, from working as the medical consultant on that case. This is not as unusual a situation as it might sound. A doctor who works as a DDS medical consultant might also see patients privately, and one of his patients might apply for disability. In that case, the doctor can provide medical information as the treating doctor, but cannot act as the medical consultant for the DDS in the disability determination for that claimant. This policy protects the doctor-patient relationship and attempts to assure that the disability decision is made without any personal bias for or against the claimant.

2. Reviewing the Decision

Depending on the state, medical consultants may be employees of the DDS or consultants who charge an hourly fee. Some medical consultants work only part-time, which can be a problem. The complexities of Social Security medical evaluations can rarely be fully grasped by someone who does the work only part-time.

What you can do about it depends on how strongly you feel about the matter. If you are concerned that your application received an inappropriate medical review, ask the director of the DDS the following:

- the name and medical specialty of the doctor who reviewed your claim
- how long that doctor has worked for the DDS, and
- the average amount of time the doctor spends at the DDS per day or week.

The director should answer the questions because they have the doctors' contracts. In addition, the doctors' contracts are probably available as public records in your state's finance and administration department, since they are paid for through state coffers.

If you are really concerned about the doctor who reviewed your claim, ask the DDS director to have your records reviewed by a different medical consultant—specifically, one with more experience or knowledge of your medical condition. If the SSA has already denied your claim, ask the DDS director to recall your claim and reopen it. You can make this request for any reason up to a year after you have been denied benefits. (Re-openings and revisions are discussed in Chapter 12.)

E. If Your Claim Is Granted

The DDS medical consultant approves the medical part of the determination and the examiner approves the nonmedical portions. Both sign the appropriate final disability determination form. Your file is then returned to the SSA Field Office from the DDS. The SSA will complete any outstanding nonmedical paperwork, compute the benefit amount and begin paying benefits.

The SSA is responsible for notifying you. A notice should be mailed to you between seven and ten days after the DDS decision. However, the time it actually takes for the necessary paperwork to be completed depends on workloads. Also, your claim could be slowed by months if, after the DDS decision, it is chosen for review by an SSA Disability Quality Branch (DQB) located at an SSA Regional Office. You will not be told if your case has been selected for review, but you can find out by asking your DDS examiner. Still, there is nothing you can do to speed up the process if your case has been chosen for review.

The SSA Field Office sometimes makes errors in benefit computation. Chapter 13 contains information about benefit computation, but this is a complex area. If you have any question about receiving the right amount of money, don't hesitate to call your local Field Office and discuss it with them. Remember, however, that being found entitled to benefits doesn't necessarily mean you will get money at the same time. SSDI claimants can't get money until after a five-month waiting period and SSI claimants can't get money until the month after they apply (see Chapter 10).

F. If Your Claim Is Denied

If the DDS denies your claim, it returns your file to the SSA Field Office, where it will be held for at least 60 days and possibly several years. From the Field Office, your file is sent to a national storage facility. If you want to appeal or understand why you were turned down, you or your designated representative can ask to review your file. (See Chapter 12 for a comprehensive look at the appeals process.)

If you get your file, look for Form SSA-831, Disability Determination and Transmittal—it's usually at the front of the file. The DDS claims examiner and medical consultant must complete this form in every initial and reconsideration application. If you have applied more than once, your file will contain multiple forms.

Even if the form was signed by a medical consultant, it may not have been reviewed by a doctor. To see if the medical consultant who signed the form reviewed your file, look for medical notes or a residual functional

capacity (RFC) rating form. If you can't find notes or an RFC form, it's quite possible that your claim was not reviewed by the medical consultant. (Children do not receive RFCs, so no such form would be expected in their file, but you would still expect to find a doctor's notes.)

If it appears that your file was not reviewed by a medical consultant, write and call the DDS director. State that your file contains no evidence that your claim was reviewed by a doctor, except for a signature on the Disability Determination and Transmittal Form. Demand that your claim be recalled and reviewed by a medical consultant. If the director won't help you, contact your senator or congressional representative, as well as your governor and local state legislator. You have a right to have your medical records reviewed by a medical consultant.

Of course, your claim can be denied whether or not it is reviewed by a DDS medical consultant. Chapter 11 contains a discussion of the different ways claims can be denied. Chapter 12 discusses the various types of appeal available to you.

G. DDS Corruption and Incompetence

Corruption and incompetence involving the DDS are probably the last thing on earth you want—or the SSA wants you—to think about. Still, it's possible that your claim is or will be denied for reasons unrelated to the criteria established under Social Security disability rules and regulations. This section helps you understand why corruption and incompetence might have an impact on your claim—and what you can do about it.

There are two basic reasons you should be interested in corruption and incompetence in the DDS:

- As a claimant, you may be cheated out of a fair decision on your claim.
- As a taxpayer, your money may be being spent in ways other than intended.

Unfortunately, anyone engaged in corrupt activity isn't going to make it easy for you to detect—but hopefully this section will help you know what to watch out for.

1. How Corruption and Incompetence Can Influence Your Claim

Honest error and missing information can play a role in denials of deserving claimants. Unfortunately, denials may also result from corruption or incompetence. The SSA may not be aware of the corruption or incompetence in a particular DDS—or may overlook what it does know.

Here are some real-life examples of the kinds of activities that can go on.

a. Corrupt Directors

DDS directors are appointed by state governors. Some directors may be appointed by a governor with more interest in political goals than in delivering quality service. A corrupt director isn't necessarily as concerned with the overall allowance or denial of benefits as with *which claims* are allowed or denied. For example, a corrupt director might try to allow large numbers of claims that are politically sensitive—such as children—while keeping a medical consultant in the agency who unfairly denies large numbers of adult claimants. Typically, a director or senior level manager pressures others into doing something wrong. This hides the director's activities. A few specific instances of the practical application of corruption are given below.

i. Developing Illegal Policies

It is illegal for a director to manipulate the DDS's allowance rate by pressuring medical consultants and other staff to allow a specific quota of favored types of claims. It is also against the law to speed up claim processing by giving examiners authority they do not have under law—such as making medical determinations on whether impairments are not severe (slight) or qualify under the Listing of Impairments, or completing residual functional capacity (RFC) forms. This means that medically unqualified people may have made your determination.

ii. Blocking Finished Claims

A corrupt DDS director can order DDS employees to hold finished claims and not forward the decision to the SSA unless the decision is one the director wants.

For example, one DDS director physically held many hundreds, if not thousands, of finished claims that were denials. Only allowances were put into the DDS computer that was connected to the SSA. The result was an artificially high allowance rate, which allowed the agency to escape criticism by certain political action groups. Unfortunately, the denials sat for months and had many claimants wondering where their claims had gone. This prevented the denied claimants from going on to a timely appeal.

iii. Controlling the Chief Medical Consultant

The chief medical consultant (CMC), as you might guess, is the head of the medical staff at a DDS. A corrupt director can anonymously control all medical determinations by controlling the CMC. If the CMC is weak or dishonest, the director can insist that he or she approve medical policies the director favors. Again, this means a medically unqualified person (the director) may be influencing your medical determination.

b. Incompetent Directors

Good administration of a DDS requires education, knowledge, skill and experience. However, a governor might appoint an unqualified person. For example, the director might have no experience with Social Security disability or fail to have the necessary education. You should be able to find out about the director's qualifications by calling or writing the director himself, or the governor's office. It is in your best interest to know the director's qualifications and to make sure the governor knows what you think.

c. Problematic Medical Consultants

Sometimes, a file is incorrectly handled at a DDS because of medical consultants who are either not able or not willing to make medical decisions according to the SSA's rules and regulations. Some can be pressured by a DDS director to make the medical determinations that the director wants.

i. Lacking Ability or Judgment

Some medical consultants have serious emotional problems that can affect their ability to use the clear, rational thinking that is needed to make accurate

disability determinations. Others may be affected by drug or alcohol abuse, or suffer nervous system damage that affects their thinking. A medical consultant with a limited knowledge of English can make mistakes in interpreting and discussing medical data.

Some consultants have specific limitations that can affect your claim. As an important example, a blind medical consultant cannot evaluate the meaning and validity of medical data such as heart tracings (EKGs), visual field charts or breathing tests. In other words, they are unable to provide an independent evaluation of test results as required by federal regulations for disability determination. An independent evaluation requires a medical consultant to personally examine the various graphs and tracings to make sure the test was performed correctly and that the laboratory's reported results are accurate. This requires good vision. Such data is a large part of many files—especially the files of claimants with heart or lung disease. It does no good for a blind consultant in these instances to have an aide to read to them, because the aide would not be qualified to interpret such raw medical data. A blind consultant should not make determinations in these types of claims.

ii. Acting With Malice

Some medical consultants routinely deny claimants because of personal bias against people receiving disability. At one DDS, a medical consultant commonly denied claimants with terminal cancer, terminal heart disease, severe arthritis and terminal lung disease. He denied about 800 claimants a year who were legally entitled to benefits. Conscientious examiners would not take serious impairments to him, for fear he would deny the claimants. Other examiners, however, were quick to give him cases in order to get a fast decision. No DDS director would terminate his contract because he—and those who were happy to work with him—moved along enormous numbers of cases. This DDS looked good in federal statistics—it had one of the fastest processing times in the country. This consultant's unfair reign of terror ended only when he died.

iii. Stealing Time

Some DDS medical consultants work at other medical jobs while supposedly working at the DDS. Imagine a

doctor who does telephone consulting work or takes calls from private patients while supposedly reviewing disability files. Obviously, there are many problems with this. First, the doctor is double-dipping, getting paid by the government while not working for the government. Second, the doctor has less time to review claims while lining his pockets with extra money. One of those delayed claims could be yours.

d. Problematic Claims Examiners

Some examiners are lazy. They cut corners everywhere they can and do the minimum amount of work necessary. One DDS director lowered state performance standards so the worst examiners could keep their jobs. Other examiners might try to manipulate medical determinations by removing written medical opinions they don't like from files and then taking the claim to a different doctor, hoping for a different decision. Their supervisors may do the same thing. Additionally, examiners—like medical consultants—can have emotional, alcohol, drug abuse or other problems.

e. Disregarding Federal Laws and Regulations

Federal regulations require the SSA to take the disability determination procedures away from a DDS that doesn't follow the law. It's rare, however, for the SSA to take such action. Various DDS offices around the country have been found guilty of violations such as not reviewing information from treating doctors and not considering a claimant's age, education and work experience—but these violations were decided by federal courts, not by the SSA. And the punishment was minimal: make the DDS rereview the claims. Such gross and intentional negligence can be disastrous to your claim.

f. Political Pressure and "Crazy Checks"

An SSA problem known as Crazy Checks illustrates how badly things can go wrong with the SSA's administration of its disability program.

In 1990, the U.S. Supreme Court ordered the SSA to change the way child disability claims were evaluated. Following the court's order, the SSA created new child disability regulations. Special interest groups pressured

some DDS directors into seeing the new regulations as an opportunity to allow most child claims. At many DDS offices, more than 90% of child claims were granted. Directors felt secure—claimants don't complain about getting benefits. Medical consultants, however—particularly those with expertise in the diagnosis and treatment of child disorders—felt otherwise. Some resigned their jobs. Others, especially those who tried to expose the problem, were terminated.

The DDS offices that continued objective evaluations of child claims had only a modest increase in the percentage of child claims allowed. Certain special interest groups labeled their states “aberrant.” The SSA was pressured into sending the aberrant state list to all DDS offices; many offices were terrified at seeing their state on the list. Being on the list subjected every DDS office in that state to having more claims reviewed by the SSA's Regional Offices and negative news media coverage. To avoid being on the aberrant state list, a DDS had to grant an extremely high percentage of child claims.

Word got around to parents receiving SSI that it was easy to get a crazy check for their child and SSI child applications increased. DDS offices granted these applications more and more for minor disorders.

Allowance awards were so out of hand that the U.S. General Accounting Office, state legislatures and many newspapers investigated why nondisabled children were receiving benefits. At first, the SSA denied that there was a problem. That didn't work, so the SSA tried to quiet criticism by doing its own studies that supported the SSA position. That didn't work either. Finally, the SSA claimed that the excessive allowances were caused by misunderstandings in the DDS offices.

Congress wasn't impressed, and amended the law, changing the definition of child disability. Large numbers of nondisabled children were removed from the benefit rolls, as the SSA was forced to undo its mistakes.

Special interest groups and newspaper articles again attacked the SSA for removing children from the disability rolls. To escape being called nasty and mean, the SSA again claimed it was all a misunderstanding by the DDS offices. The SSA held national retraining classes for DDS medical consultants and examiners. After these sessions, thousands of cases were sent

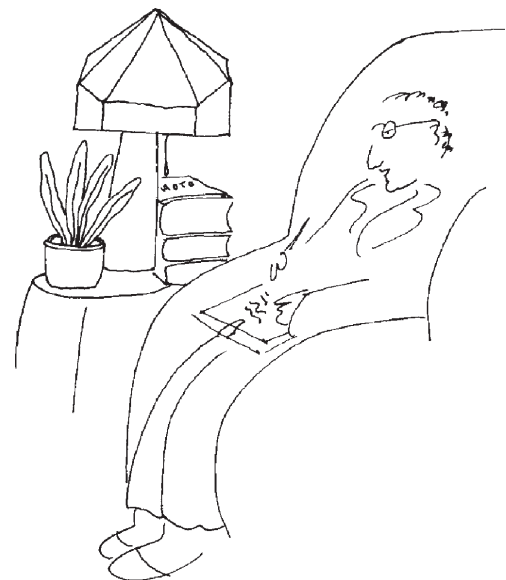
back to the DDS offices for rereview as often as was necessary until benefits were granted.

2. What You Can Do About Corruption and Incompetence

Your goal is to get a fair decision on your disability claim, not to get into a personal conflict with DDS personnel or to accuse them of malfeasance. But you have the right to have an intelligent, capable and unbiased person review your claim. So here is how to minimize the effect of these problems on your claim:

a. Take Preventive Action

You can try to prevent any problems by notifying the DDS in writing that you expect only actions on your claim that are authorized by federal law, and only qualified, competent individuals to work on your claim. Send the letter as soon as you file your application to the DDS, with copies to your state and federal representatives. This alerts DDS personnel that you will pay careful attention to exactly what they do. This, alone, will maximize your chance of a quality review. The DDS is required to make all correspondence from you a part of your file. If you have an attorney, his or her signature to a letter like this will make the DDS pay even more attention.



Sample Letter

Date: 12/12/0x

Bill Smith
1234 William Drive
Williamsburg, VA.

Bob Smythe
Disability Determination Service
1234 Bobson Lane
Bobtown, VA

Dear Mr. Smythe:

I have applied for disability because of the following impairments:

1. Depression
2. Heart Disease
3. Lung Cancer

I hereby request assurance in writing that my claim will be reviewed by a licensed medical doctor or osteopath (for physical impairments) or by a licensed psychiatrist or properly qualified psychologist (for mental impairments). I object to, and want to be informed of, nondctors participating in the medical part of my disability determination. If my claim is not reviewed by a medical consultant, I hereby request that you tell me in writing your personal qualifications to make medical evaluations on my claim, including whether you are licensed to practice medicine or psychology in this state.

If you receive instructions from a supervisor who is not licensed to practice medicine, osteopathy or psychology regarding the medical severity of my impairments, I hereby object to the use of such instructions and request that I be notified of these instructions before a final determination on my claim is made.

Furthermore, I do not want my claim reviewed by any medical consultant the DDS knows has problems that may interfere with his or her ability to review my file and make competent medical determinations. Specifically, I do not want my claim reviewed by a medical consultant with an uncontrolled serious mental disorder such as schizophrenia or manic-depressive illness; a medical consultant who has had serious strokes or other type of brain disease or brain damage sufficient to affect his or her ability to think clearly; a medical consultant who is known to have an active drug or alcohol abuse problem; or a medical consultant who is unable to read my medical records or to see what documents to sign, unless that medical consultant has an aide.

Sample Letter (continued)

I also do not want my claim reviewed by any medical consultant who the DDS knows or has reason to know is “denial oriented”—that is, who denies a significantly higher percentage of claims than do other medical consultants working in the same agency on the same types of claims. I demand a fair consideration.

I also request that my claim not be handled by a claims examiner who has any of the types of problems described above.

If this DDS office is involved in any type of special pilot project for the SSA that means my claim will be handled in ways different from the way claims are handled in other states, please inform me of the nature of such project so that I may protect my rights.

Finally, I request that this letter remain in my file for use in my appeal, if necessary. Under no circumstances do I authorize removal of this letter from my file.

Sincerely yours,

Bill Smith

cc: Rep. Bob Williams (D-Va)
Gov. William Bob (D-Va)
Sen. Will “Bob” Williams
Sen. Wilhemina Willems
Rep. Woody “Will” Williamson

3. Remain Actively Involved in Your Claim

If you become aware of a specific problem involving the handling of your claim, you are not helpless. Here are some suggestions on how to proceed.

- Call your claims examiner, and her supervisor, if necessary, to discuss the problem. If, for example, they did not show your claim to a medical consultant, they may change their thinking if you remind them of your right to such review—and let them know you will complain to the agency director if they don't comply. Even if the law changes and medical review becomes technically unnecessary (see Section H, below), let them know that you believe medical review is appropriate in your case. Be sure to follow up with a letter outlining your complaint. This assures that your file contains your complaint and your understanding of what the examiner or supervisor said to you.
- Call the DDS director. Let him know that if the problem is not resolved to your satisfaction, you will write the governor's office and your state and federal representatives. Calling a director is effective because it puts him on the spot—with you on the other end of the telephone, he is more likely to agree to take some action on your complaint than he would in response to a letter which he can file away and forget. But always follow up this call with a letter outlining your complaint and the director's response.
- Write your legislators and send a copy to the DDS director. Your complaint will become a part of your file and the DDS director knows that you are serious—not just somebody who made a telephone call and gave up.
- Write the SSA's Office of Inspector General (OIG), who is charged with investigating SSA (including DDS) wrongdoing—fraud, waste, abuse and mismanagement. (Send copies to the DDS director and your state and federal representatives.) There is no guarantee that the OIG will think your complaint has merit, but you have nothing to lose by trying. Do not be afraid the DDS will take some kind of revenge because you complain to the OIG; the opposite is more likely. If the DDS director knows you have gone so far as to

complain to the OIG, the office will handle your claim with kid gloves.

The OIG can be reached in various ways:

SSA Fraud Hotline

P.O. Box 17768

Baltimore MD 21235

800-269-0271 (voice)

410-597-0118 (fax)

www.ssa.gov/oig (website)

Also consider talking to your local newspaper. The DDS offices and the SSA don't want bad publicity, and a mistreated claimant can often get a story in the newspaper. Too much bad publicity may embarrass the governor, and you can be sure the DDS director will be asked about it.



You may find that attorneys are reluctant to spend too much time on the DDS process. They may tell you that it is useless to deal with the DDS, since it denies most claims. But DDS officials typically allow about 30%–40% of initial claims and 10%–15% of reconsideration claims—about half of all requests. It is not useless to deal with the DDS. A good attorney will do all she can to get the DDS the information it needs about a claimant. Appeals beyond the DDS can take a year or longer—even several years—so you want to avoid that, if possible.

H. Disability Redesign: Coming Danger to Claimants

The SSA is in the process of redesigning the disability determination process so that nondoctors will be allowed to evaluate the severity of medical impairments. Parts of this redesign may be helpful, but eliminating medical determinations by medical consultants should be scary to any potential claimant. Individuals responsible for claims under the new redesign will be called claims managers or something equivalent, and pilot projects are already underway in several states. If you look at your file at the Field Office or DDS and you have any question about why your claim was denied, check to see if a medical consultant reviewed the case.

The SSA has responded to complaints by assuring that medical advice will be sought when needed. This is no assurance. Claims managers might ask for advice from medical consultants in some cases, but in truth

they will be free to make their own judgments, decide when to ask for medical advice and reject medical advice they are given. Claimants will suffer if their disability determinations are made by nondoctors. Ask yourself if you would go to a nonmedical person to be treated for a serious disease. If not, why would you be satisfied with a nondoctor deciding the severity of your medical disorders?

In the 1970s, the SSA let examiners make medical determinations without any medical consultant input. The examiners made many errors in both allowances and denials, and the SSA eventually developed regulations requiring medical determinations by doctors. It is appalling that the SSA is trying to return to its old ways. It is already difficult to get good doctors to work in DDS offices because of the relatively poor pay. However, the medical knowledge of even the worst doctor far exceeds that of examiners. Problems with the quality of doctors can't be solved by changing

over to nondoctors. To use an analogy, pilot error sometimes causes crashes with commercial airliners. It is not an improvement to lower the standards so that nonpilots can fly the airplanes. Yet that is exactly what the SSA is planning to do, get doctors out of the picture and control the decisions the way they want.

If you want your claim reviewed by a medical consultant, demand it. Ask the claims examiner or manager who reviewed your file. If the examiner or manager refuses to tell you, demand to talk to the supervisor. If you get nowhere, call and write the DDS director. If the DDS director gives you the run-around, call your governor, state legislator, senators and congressional representative to complain.

If the DDS will not have your file reviewed by a medical consultant, consider contacting a local newspaper. Newspapers are often interested in doing stories on important issues like the abuse of disabled people, and the SSA's redesign plan is such an abuse.



Chapter 7

How Claims Are Decided

Step 1. Are You Engaged in Substantial Gainful Activity?	7/2
Step 2. How Severe Are Your Impairments?	7/2
Step 3. Do You Meet the Listing of Impairments?	7/2
Step 4. Can You Do Your Prior Job?	7/3
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Any time your claim for disability is evaluated—whether at the DDS, on appeal to an administrative law judge (ALJ) or in federal court—SSA procedures require that specific issues be addressed in a specific order. This is done to make sure that everyone gets the same consideration. If at any point in the sequential analysis, the DDS, SSA, ALJ or federal court judge determines that your impairments justify disability, the evaluation ends. This chapter explains the sequence of events that is used at every level in the disability determination process. (See Chapter 12 for more on the different levels of disability review.)

Step 1. Are You Engaged in Substantial Gainful Activity?

If you are working and making a certain amount of money, you may be engaged in what is called substantial gainful activity (SGA). If so, you are not eligible for disability. SGA is discussed in Chapter 1, Section B1. If you are not performing SGA, the analysis proceeds to Step 2.

Step 2. How Severe Are Your Impairments?

The second step involves a determination of the severity of your impairments. If they do not (or should not) significantly limit the work you could do, your impairment will be considered not severe (or non-severe, mild or slight). Your claim will be denied if your impairments individually or combined are not severe.

The presence of one or more impairments doesn't necessarily mean you are disabled. Their effect on your ability to function mentally or physically is what matters. For example, you have severe hypertension (high blood pressure) which limits the amount of physical work you can safely do. But if your hypertension is controlled with drugs so that your blood pressure is normal, your impairment would be considered not severe. Similarly, a nearsighted person for whom everything is a blur without glasses but clear with glasses does not have a severe impairment.

On the other hand, if you have retinal disease that blurs your vision and cannot be corrected with glasses, your impairment would be more than “not severe.” So would painful arthritis in your spine that cannot be improved surgically. Many medical conditions cover the range of severity from not severe to incapacitating. Information on various medical disorders is set out in Chapters 16 through 29.

If your impairments are determined to be significant—that is, they are more than “not severe”—the analysis proceeds to Step 3.

Step 3. Do You Meet the Listing of Impairments?

At the first stage of review, the DDS will compare your disability to a list—called the Listing of Impairments—to see if your impairments are severe enough to meet or equal the SSA requirements. The Listings are federal regulations, found at 20 C.F.R. Part 404. If you are denied at the DDS level, each level of appeal will also use the Listing of Impairments to consider whether the DDS should be overruled. (The Listings are described in Chapters 16 through 29.) Each impairment in the listing specifies a degree of medical severity which, if met by an applicant, presumes that she cannot function well enough to perform any type of substantial work. The listings differ for adults and for children.

The Listings cover most frequently found impairments. If any of your impairments exactly match the criteria of a listing, you will be found disabled and granted benefits regardless of your age, education or work experience.

If none of your impairments meet a listing, then the reviewer must determine if your impairments are equivalent to the severity required for your impairment or a similar impairment. (This is called “an equal.”) Allowing benefits based on the equal standard recognizes that it is impossible for the SSA to put all impairments in the Listings. If the SSA says your impairments are as severe as those in the Listings, you will be granted benefits.

Reading the Listings

SSA staff, DDS examiners and medical consultants, hearing officers, administrative law judges, appeal council judges and federal judges all refer to listing letters and numbers to identify specific listings. These numbers come directly from the federal regulations governing Social Security, namely 20 C.F.R. Part 404. It is important for you to understand this system so you can communicate clearly with the SSA and DDS. A typical listing may be expressed using familiar letters and numbers:

#.##

A.

1.

a.

b.

c.

2.

a.

b.

B.

1.

2.

a.

b.

The #.## represents the listing number. Adult heart disease, for example, is listing 4.04. Each capital letter introduces a new condition that might qualify for a listing. The numbers further subdivide a condition; usually, you will qualify if you meet one of the numbers. What this means, for example, is that you might meet a listing if you meet B1. The lowercase letters add another level of complexity. In some cases, you must meet all those conditions; in other cases, only one. For example, you might meet a listing, above, if you match A1a, A1b and A1c. Or, you might meet a listing if you have only B2b. This varies from listing to listing.

Because of the ways the listings are numbered, Chapters 16 through 29 are not formatted like the rest of the book. Knowing this, it is easy not to confuse listing numbers with chapter sections.

For your impairments to be considered equal to a listing, the reviewer must find one of the following to be true:

- Your impairment is not listed, but it is of the same medical severity as a listed impairment.
- You don't meet the criteria of a listing, but your medical findings have the same meaning as the listing criteria. For example, you might have a laboratory test not mentioned by the listing, but that shows the same thing as the type of test in the listing.
- You have a combination of impairments. None alone is severe enough to meet a listing, but together they are equivalent to listing-level disability. For example, you have heart disease and lung disease which together cause you much greater severity than either alone.
- For a child applying for SSI, the impairment is considered a functional equal of those that satisfy the listings. The functional equal standard allows benefits to children who don't quite have the medical severity needed to meet one of the above three points, but who have the same amount of functional loss caused by their impairments. Relatively few children have impairments that qualify as functional equals.

If your impairments or combination of impairments do not meet or equal any listing or combination of listings, the analysis proceeds to Step 4.

Step 4. Can You Do Your Prior Job?

If your impairments do not meet or equal any listing, the reviewer will consider whether they are severe enough to prevent you from doing your prior work (if any). If your impairments are not that severe, your claim will be denied with the rationale that you can return to your prior work.

If you cannot perform your prior work, the analysis proceeds to Step 5.

Step 5. Can You Do Any Other Job?

If your impairments prevent you from doing your prior work, the reviewer will consider whether or not there are other jobs in the national economy that you can do. If so, your claim will be denied with the rationale

that there are jobs that you can perform. However, if you cannot transfer your skills to other work, your claim will be allowed. Be clear about this: the SSA does not have to find you a particular job, or a job of equal pay, or a job of equal skill, or jobs near where you live in order to deny your claim. ■

Chapter 8

If You Can Do Some Work

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If your medical impairments are more than slight or mild, but not severe enough to meet or equal a listing, then the SSA will consider what it calls your residual functional capacity, or RFC. (Listings are discussed in Chapter 7 and are contained in Chapters 16 through 29).

An RFC analysis is an assessment of what the SSA thinks you are physically or mentally capable of doing, despite the limitations from your impairments and related symptoms. In other words, an RFC outlines what remaining (residual) capacities you have to do things (function) in a medical sense; an RFC may also specify some things that you cannot do. For example, an RFC might say that you can lift 50 pounds occasionally, but that you cannot work in places where there is an excessive amount of dust and fumes.

The RFC assessment is a medical decision, not a determination as to whether or not you are disabled. An RFC does not state whether you can do specific types of jobs. Rather, it is used by SSA examiners and vocational analysts to determine the types of work you *might* be able to do. If your remaining capabilities make it possible for you to continue with your prior job, the SSA can deny your claim because you can return to that type of work. The SSA doesn't have to actually find you a job or call your previous employers and ask them if they will take you back.

If your RFC restricts you so much that you cannot return to any of your past jobs, the SSA will also consider your age, education and work experience (called your *vocational factors*), to determine whether you can do any work. If the SSA concludes that you cannot, then you will be allowed disability payments. (Vocational factors are discussed Chapter 9.) If the SSA awards you benefits based on your impairments and your RFC assessment, you receive a *medical-vocational* allowance; if your claim is denied after this kind of analysis, you receive a *medical-vocational* denial.

If the RFC limits you to jobs that are significantly lower paying than your current or previous work, the SSA will not pay you the difference; there are no partial disability payments under Social Security—it is an all-or-nothing decision. RFC assessments are only done on adult claims.

tion claim or continuing disability review at the DDS. On appeal, an administrative law judge or federal judge can do the RFC assessment. A redesign of the SSA disability system currently underway may change this procedure, resulting in a doctor never seeing your claim—even at the initial, reconsideration or Continuing Disability Review stage. (See Chapter 6, Section H.) If your RFC was done at the DDS, and the handwriting on the assessment doesn't match the doctor's signature, a doctor may not have done your RFC. This would be a violation of current federal regulations, and you should contact the SSA's Office of Inspector General at 800-269-0271 or on the Internet at www.ssa.gov/oig.

Your RFC is assessed based upon all relevant evidence, including your description of how your symptoms affect your ability to function. In addition, the SSA may consider observations of your treating doctors or psychologists, relatives, neighbors, friends, coworkers, the SSA intake person and others. The SSA uses your statement, the observations of others and your medical records to decide the extent to which your impairments keep you from performing particular work activities. The SSA must have reasonably thorough medical evidence.

The SSA has two different RFC assessments: one for physical impairments and one for mental impairments. The medical consultant will not do a physical assessment if you have only a mental impairment. Nor will the consultant do a mental rating if you have only a physical impairment. Many cases, however, require both.

RFCs are not assessed in numbers, percentages or other scores. Instead, work abilities are put into categories. The lower your RFC category, the less the SSA believes you are capable of doing. For example, a physical RFC for light work is lower than a physical RFC for medium work. A mental RFC for unskilled work is lower than a mental RFC for semiskilled or skilled work. Your RFC may be additionally lowered if you cannot perform certain work-related activities, such as pushing and pulling, very often. The lower your RFC category, the less likely the SSA will say there is some work you can do. That is because the SSA cannot deny your claim on the basis that you can do work that falls into a higher RFC category than the RFC you received. For example, if you receive a physical



Learn who did your RFC. A doctor must determine your RFC during your initial claim, reconsidera-

RFC for sedentary work, you cannot be expected to do a job requiring light, medium or heavy work. Similarly, if your mental RFC is for unskilled work, you cannot be expected to do semiskilled or skilled work.

A. Physical Impairments and Abilities

This section focuses on how the SSA assesses a physical RFC. In some cases, specific medical disorders are discussed simply for clarification. How the SSA combines a physical RFC with the vocational factors of age, education and work experience is discussed in Chapter 9. Chapters 16 through 26 and 28 through 29 provide the SSA listings and RFCs for specific physical disorders.

When the SSA assesses your physical RFC abilities, it first makes a medical judgment about the nature and extent of your physical limitations. If you have limited ability to perform certain physical activities associated with working, such as sitting, standing, walking, lifting, carrying, pushing, pulling, reaching, handling, stooping or crouching, the SSA may conclude that you cannot do your past work or any other work.

A physical RFC will not take your age into consideration, except in certain continuing disability review claims (see Chapter 14). But the SSA does not ignore age; it is considered when you cannot do your prior work and the SSA is determining if you can do any work. In other words, your RFC will not be lower because you are 60 years old and not as energetic as you were at age 30.

Not only doesn't your age matter, but your sex and physical strength are also irrelevant unless they are related to your impairments. Here's how this plays out. Never in your life have you been able to lift 50 pounds, much less 100 pounds. But if there is nothing significantly wrong with you, the SSA may give you an RFC saying you can lift 100 pounds. At first glance, this seems illogical and unfair. But restricting RFCs for nonmedical reasons would result in granting benefits to some people who have no significant impairments, and that would defeat the meaning of the disability system.

The areas assessed in a physical RFC are described in the rest of this section.

1. Exertion

In the exertion category, the SSA evaluates lifting, carrying, standing, walking, sitting and pushing and pulling. If these abilities are not affected by your impairments, you might still be given an RFC for non-exertional work if you have difficulty seeing or hearing or if you cannot work in certain environments. Many claimants have exertional restrictions on their RFC because of impairments that affect physical strength and stamina. Other claimants, especially those suffering from arthritis of the joints or spine, have reduced exertional ability on their RFC because of pain. Disorders of the nervous system, lung diseases and heart and blood vessel diseases also account for large numbers of exertional restrictions because of decreased strength and stamina, and because of symptoms such as fatigue, pain and shortness of breath. If your RFC restricts your exertion, it must explain why your impairments justify the limitations.

Lifting or carrying exertional abilities are measured by the descriptive words “frequently” and “occasionally.” Frequently means you can lift or carry for at least one-third but less than two-thirds (cumulative, not continuous) of an eight-hour workday. Occasionally means you can lift or carry for less than one-third of an eight-hour workday.

Pushing and pulling exertional abilities are measured in terms of “unlimited,” “frequently” and “occasionally.” Frequently means you can push and/or pull for at least one-third but less than two-thirds of an eight-hour workday. Occasionally means you can push and/or pull for less than one-third of an eight-hour workday. A lot of jobs, especially those involving heavy equipment, require pushing and/or pulling. Any impairment that affects use of the hands, arms or legs could result in a restricted RFC. Arthritis is probably the most frequent cause of limitations. Strokes, with the weakness they can cause, usually involve one arm and one leg on the same side of the body, and are another common reason for limitations in ability to push and pull.

Exertional abilities are divided into five categories:

Heavy work. Heavy work is the ability to lift or carry 100 pounds occasionally and 50 pounds frequently, and to stand or walk six to eight hours a day. The SSA rarely gives an RFC for heavy work. In general,

the SSA believes that a person who can do heavy work has no exertional restriction and is rated not severe—that is, not disabled.

Medium work. Medium work is the ability to lift or carry 50 pounds occasionally and 25 pounds frequently, and to stand or walk six to eight hours daily. Medium work is an RFC given to claimants whose exertional ability is moderately limited. What is moderate? That's a matter of medical judgment

Light work. Light work is the ability to lift or carry 20 pounds occasionally and ten pounds frequently, and to stand or walk six to eight hours daily. Light work is an RFC given to claimants who can't do medium work, but are not restricted to sedentary work. Again, this is a matter of medical judgment. A claimant with a missing hand or arm is usually restricted to no more than light work. If you can't stand or walk at least six hours daily, you will not be able to do light work or more. That means that your RFC can't be for more than sedentary work. This is to your advantage as an applicant for disability benefits because it markedly limits the jobs you can do.

Sedentary work. Sedentary work requires lifting no more than ten pounds at a time and occasionally lifting or carrying articles like small files or small tools. Although the work is done primarily while seated, up to two hours per day of walking and standing may be necessary. If the SSA says you can stand four hours daily, then your RFC is between sedentary and light work. Although this is possible, the SSA tries to avoid such blurry distinctions. Such an RFC would require careful evaluation by a vocational analyst on how it affects your ability to return to your prior or other work. (See Chapter 9 about medical-vocational evaluation.) While sedentary work does not require much lifting or standing, even unskilled sedentary jobs often require good use of the hands and fingers for repetitive hand-finger actions. A sedentary RFC is given to those claimants whose impairments are not quite severe enough to qualify under a listing.

Less than sedentary. This is not an official RFC category, but it is an RFC rating sometimes given. It will almost always result in allowance of the claim, because the examiner or vocational analyst will not be able to find any jobs the claimant can do. There are rare exceptions of some highly trained claimants who had less than sedentary jobs when they applied

for disability; the SSA might return these people to their prior work.

Sedentary work requires good use of the hands. If you can't stand or walk at least six hours daily, and you don't have excellent use of *both* of your hands, then you cannot do even sedentary work. Similarly, if you start out with a sedentary RFC but need to use one hand for an assistive device to help you walk, such as a cane or crutch, then you actually have a less than sedentary RFC although your hands and arms may be normal.

In addition, if you must periodically alternate between sitting and standing to relieve pain or discomfort, this medical restriction eliminates most sedentary jobs and will result in a less than sedentary RFC. Most claimants who must alternate sitting and standing have very severe back pain. Because this restriction applies so infrequently, the SSA requires a special explanation as part of the RFC assessment.

In most instances, claimants with a less than sedentary RFC could equal a listing or combination of listings without their claims ever having to go the RFC step of the sequential analysis.

2. Posture

Postural exertional abilities include bending, stooping, climbing, balancing, kneeling, crouching and crawling. In technical language, posture is the attitude, or directional orientation, of the body.

Postural exertional abilities are described on an RFC as never, frequently or occasionally. Frequently means you can do the activity at least one-third but less than two-thirds of an eight-hour workday. Occasionally means you can do the activity less than one-third of an eight-hour workday. If the RFC gives any restrictions of posture, it must explain why the impairments justify the limitations.

Bending. An ability to bend the back (or stoop) is often needed for jobs that require lifting and carrying. This fact, coupled with the fact that many claimants allege back pain as a basis for disability, makes bending extremely important in disability determination. Degenerative arthritis and degenerative disc disease of the spine cause most back pain in claimants. How well you can bend your back is often the most important aspect of your physical evaluation.

Claimants with significant back pain almost always have difficulty bending and are usually limited to only occasional bending. This limitation can be very important because most medium or heavy work requires frequent bending. If you receive a medium RFC regarding lifting and carrying and an occasional RFC for bending, you are likely to be referred for only light work when referring to the medical-vocational rules. Depending on your age, education and work experience, this change can make the difference between allowance and denial of your claim.

Some claimants cannot bend their spine to any significant degree. This usually happens in people who have surgical fixation of the spine because of spinal fractures, advanced osteoarthritis of the spine or an inflammatory disease known as ankylosing spondylitis. But even these people will not automatically qualify for disability—depending on the vocational factors, some will not be granted disability.

Balancing and climbing. Difficulties in balancing are most frequently caused by significant impairments of the nervous system or inner ear. In such a situation, an RFC should include a statement that the claimant should not be required to do work requiring good balance. Climbing, except for steps with handrails, would also be prohibited when balancing is restricted. Limiting climbing when balance is not restricted might occur in cases of weakness in an arm or leg or in cases of arthritis in a hip or knee joint. The RFC may need to specify the kind of climbing that is limited—such as ramps, stairs, ladders, ropes or scaffolds. An RFC should not simply limit all balancing or climbing. If it did, the claimant would not be able to walk and would qualify under a listing.

Kneeling, crouching and crawling. Limitations in kneeling, crouching and crawling are most frequently caused by arthritis in the knees. The ability to crouch may also be decreased by back pain. Limitations in these areas can be decisive in allowance or denial of a claim.

3. Manipulation

Manipulation means the ability to use the hands for various tasks. Manipulative abilities include reaching in all directions, including overhead; handling (gross

manipulations); fingering (fine manipulations); and feeling (skin receptors). Manipulative abilities on an RFC assessment are described as limited or unlimited. An RFC with any restrictions of manipulation must explain why the impairments justify the limitations. Manipulative abilities are especially relevant when a claimant is limited to using his hands less than one-third of a workday.

Reaching and handling. Reaching is most often limited by arthritis in a shoulder or elbow joint, or weakness in an arm, such as from a stroke.

Strokes are a frequent cause of decreased handling ability, due to weakness and numbness in the hands. Arthritis in the hands can also affect handling ability. Fractures of bones involving the wrist can result in markedly decreased use of a hand, even after optimum healing. These limitations can be caused by damaged soft tissues, such as ligaments, tendons and nerves, as well as by the lack of bone healing or the development of arthritis due to a fracture in a joint space.

Fine manipulations and feeling. Fine manipulations require coordinated, precise movements of the fingers. Impairments that result in little limitation in handling abilities can still affect fine manipulation. Disorders of the nervous system such as strokes or tremors can affect the ability to perform fine manipulations, but might not be severe enough to affect handling. Arthritis or other disorders that are associated with swelling of the fingers can affect fine manipulations. Missing fingers might not affect handling, but would prevent fine manipulations. Diabetes can damage the nerves from skin receptors involved in feeling, resulting in numbness that can affect fine manipulative ability, even though the ability to do handling remains. Fractures of wrist bones can decrease ability to perform fine manipulations, even after optimum healing. Carpal tunnel syndrome is a frequent problem of workers performing repetitive activities with their hands and wrists that can cause pain, numbness and weakness in the hands that affect manipulative ability.

Difficulty with fine manipulations has little effect on the SSA's ability to refer a claimant to jobs requiring light, medium or heavy work. Many such jobs don't require fine manipulations. Fine manipulations, however, are very important in the ability to do sedentary work. This means that if you have an RFC for sedentary work but you cannot perform fine manipulations,

your RFC drops to less than sedentary work and your claim will probably be allowed.

4. Vision

Visual abilities are described on RFCs as limited or unlimited. If an RFC gives any restrictions of vision, it must explain why the impairments justify the limitations. Visual tests and visual impairments are discussed in Chapter 17.

The RFC rating for visual limitations takes into account six factors:

Near acuity. Near acuity is important for seeing close up, such as reading a book or typewritten papers. Cataracts and retinal diseases are the most likely causes of decreased near acuity that cannot be corrected with glasses or contacts. Good near acuity is not required for many jobs for light work or higher. Also, some sedentary jobs don't require good near acuity. Therefore, being allowed disability on the basis of limited near acuity is unlikely—especially in young claimants who have flexibility in transferring to different kinds of jobs.

Distance acuity. Distance acuity is important for seeing objects more than a few feet away. Most decreases in distance acuity can be corrected with glasses or contact lenses, and are not considered limiting; some cases, such as those involving cataracts, can be cured with surgery. If distance acuity is limited and uncorrectable, but does not meet or equal a listing, you still may be unable to perform your prior work. For example, some types of manual labor might not require good distance acuity while a much more modest decrease in acuity can disqualify a person from having a driver's license—including the ability to drive commercial vehicles such as trucks.

Whether the SSA would say you can do other work besides your prior job would depend on the types of other medical problems you have and your vocational factors of age, education and work experience (see Chapter 9).

Depth perception. Depth perception is the ability to perceive how far something is from you. Depth perception is affected when a claimant is blind in one eye. Jobs such as being a pilot require good depth perception, but many other jobs don't. An examiner or

vocational analyst can usually refer a claimant with limited depth perception to a job not requiring depth perception, even if she can't return to her prior work.

Accommodation. Accommodation means the ability of the lens of the eye to change thickness in order to focus on near objects. The most common cause of inability to do this is a stiff lens resulting from normal aging; this is easily correctable with glasses. Limited accommodation is rarely a basis for disability.

Color vision. Color vision means the ability to distinguish different colors. Limitations in color vision are usually genetic, and most often limited to green and red colors. Many people with color vision deficit can still see some color. Even if you suffer complete loss of color vision, the SSA can identify general jobs that don't require color vision.

Field of vision (peripheral vision). Field of vision refers to the ability to see objects away from the center of vision. Limited fields of vision are most often the result of glaucoma, strokes and diabetic retinal disease. Claimants who have significant restriction in their fields of vision, but not enough to meet or equal a listing, may still need to be restricted from work where lack of good peripheral vision can endanger their lives or the lives of others. Specifically, the RFC should restrict the claimant from driving, working at unprotected heights or working around hazardous machinery.

5. Communication

The most important work-related communication abilities are hearing and speaking. On an RFC, communication abilities are described as limited or unlimited. Hearing and speaking impairments, as well as tests for those impairments, are discussed in Chapter 17. If an RFC gives restrictions on hearing or speaking, it must explain why the impairments justify the limitations.

Hearing. Both being aware of and understanding spoken words are important in hearing as related to the ability to work, and hearing impairments are frequently alleged by claimants. Hearing problems, however, can often be improved with hearing aids. Most claimants who have hearing impairments do not qualify under a listing, but have a significant hearing

loss that requires an RFC. Still, the SSA can identify general jobs that most claimants can perform, despite some difficulty hearing.

Speaking. The ability to speak involves clarity of speech, as well as adequate volume and production of enough words fast enough to meaningfully communicate with other people. A significant speaking impairment that doesn't qualify under a listing requires an RFC. Still, the SSA can identify general jobs that most claimants can perform, despite some difficulty speaking. Many jobs require minimal speaking.

6. Environment

Environmental factors that might place limitations on a claimant's RFC include sensitivity to extreme cold, extreme heat, wetness, humidity, noise, vibration and fumes (odors, dusts, gases, poor ventilation), and avoidance of certain dangers such as working around hazardous machinery or at unprotected heights. Limitation of exposure to a particular environmental factor can be expressed on the RFC as unlimited, avoid concentrated exposure, avoid even moderate exposure and avoid all exposure. If the RFC gives any environmental restrictions, it must explain why the impairments justify the limitations.

A patient evaluated in an office or hospital is in a special environment, one that may be very different from the environment found at many jobs. Therefore, when an examiner or vocational specialist needs to determine whether you can return to your past work or do some other type of work, the DDS medical consultant must note any relevant environmental restrictions on the RFC. The examiner or vocational analyst may need to discuss with you the kinds of environmental exposures you have had in your job.

Two impairments almost always give rise to environmental restrictions on an RFC.

- **Epilepsy.** Claimants with epilepsy who have had a seizure in the past year are restricted from working around or driving hazardous machinery and from working at unprotected heights where they might injure themselves or others if they suffer a seizure.

- **Lung disease.** Claimants with significant lung disease are usually restricted from exposure to moderate dust and fumes. Restriction from all exposure is not feasible, because there are dust and fumes everywhere, even in people's homes.

Two other conditions may give rise to environmental restrictions on an RFC.

- **Heart or blood vessel disease.** Claimants with severe heart disease, or vascular disease of the arteries, might be restricted from concentrated exposure to extreme heat or cold because temperature extremes can put dangerous stress on the heart and blood vessel system. In some instances, restriction from even moderate exposure might be required.
- **Skin disorder.** Claimants whose skin disorders are affected by constant contact with wetness should be restricted from performing work that could worsen the condition. For instance, if you have an inflammatory condition of the skin of the hands (dermatitis) that worsens with constant dipping of your hands in water, your RFC should restrict you from concentrated exposure. In some instances, restriction from even moderate exposure might be required.

Vibration is an environmental factor that does not usually make a difference in the outcome of a claim, but it can in some cases. For example, claimants have been granted disability because the only work they could perform involved riding on equipment, such as a tractor, that caused too much pain from the vibration.

Noise is not an important environmental factor in most cases, but it can be in some. This is most often the case with people with hearing impairments whose jobs required them to communicate in noisy environments; their ability to understand words is likely to be affected in the noisy environment.

7. Symptoms

The medical consultant completing an RFC should consider any symptoms—such as pain, nausea and dizziness. Symptoms important to disability determination are discussed in Chapter 5.

The RFC must address the following three concerns regarding symptoms:

- whether symptoms are caused by a medically determinable impairment—that is, whether or not they are real
- whether the alleged severity or duration of the symptoms is medically reasonable on the basis of the impairments, and
- whether the severity of the symptoms is consistent with your alleged ability to function, taking into account the medical and nonmedical evidence—your statements, statements of others, observations regarding your activities of daily living and changes in your usual behavior or habits.

The important point is that the SSA should recognize that symptoms can limit your ability to work. Joint and back pain is a common symptom, usually related to arthritis. Restrictions for arthritis are most often for pain—especially for back pain. People vary considerably in the amount of pain they feel and the SSA must evaluate each case on an individual basis. Although individual claimants can reasonably vary in the amount of pain they feel or other symptoms they exhibit, the SSA is not likely to accept a very low RFC due to pain or other symptoms when the claimant has very minor physical abnormalities.

Pain is not the only symptom that can influence an RFC. For example, some claimants have severe nausea and dizziness from inner ear disease. These people require the same kinds of restrictions as epileptics—no work around hazardous machinery or at unprotected heights.

Other claimants have nausea, weakness, numb hands and feet or potential side effects from medication taken to treat their impairments. The SSA should factor this into the RFC.

8. Statements of the Treating Physician

The RFC must specify whether your treating doctor's statements about your physical capacities are in the file. If so, the medical consultant or administrative law judge must specify whether her conclusions about what you can and cannot do significantly differ from your treating doctor's. If they differ, the medical consultant or ALJ must explain in detail why the treating

or examining doctor is wrong (see Chapters 6 and 12). The SSA is supposed to accept your treating doctor's opinion regarding your functional abilities, if that opinion is consistent with the evidence in the file. (See Chapter 5 for more information about treating and examining source opinions.)

B. Mental Impairments and Abilities

This section focuses on how the SSA assesses a mental RFC, including how RFC factors relate to the ability to work. (See Chapter 27 for the SSA listings and RFCs for specific mental disorders.)

At the initial, reconsideration or CDR level, a psychologist or psychiatrist does a mental RFC assessment. On appeal, an ALJ or federal court judge can rule on mental RFCs. The SSA is looking for the degree of limitation of function a claimant has in each assessed area. All areas to be assessed are rated as “not significantly limited,” “moderately limited,” “markedly limited,” “no evidence of limitation in this category” or “not ratable on available evidence.” If an area is not ratable on available evidence, the SSA is obligated to obtain more information. The difference between no evidence of limitation in this category and not significantly limited is the difference between no limitation at all and a mild limitation.

The objective of a mental RFC is to produce an assessment by which an examiner or vocational analyst can determine if a claimant with a mental impairment can do skilled, semiskilled or unskilled work—or whether the claimant is incapable of doing even unskilled work. (See Chapter 9 for more on the definition of these types of work.) The examiner or analyst uses the information to determine if the claimant can return to his prior work or perform some other kind of work.

The most important determination in a mental RFC is whether you are mentally capable of doing unskilled work. The reason for this is that even if you are no longer capable of returning to your prior job that required semiskilled or skilled work, the SSA can still identify unskilled jobs. For example, a lawyer, whose work is skilled, is in an automobile accident and suffers brain injury resulting in significant permanent

mental impairment. Because of the brain damage, he is no longer capable of skilled or even semiskilled work. This lawyer, however, is capable of unskilled work. Under these conditions, the SSA could deny the lawyer's claim for disability benefits by identifying unskilled jobs that he could perform. This is a reminder of the important principle in disability determination: a claimant must be incapable of performing *any* work to be disabled—not just his prior job.

Consider, on the other hand, a mental RFC that shows a claimant with chronic schizophrenia or severe depression who cannot do even unskilled work. The SSA would allow the claim, regardless of the claimant's age, education or work experience.

Because of the large number of unskilled jobs in the economy, a claimant with a mental impairment alone who has a mental RFC for unskilled work is almost never going to be allowed benefits. (For the rare exceptions, see Chapter 9, section C3.) This does not mean that mental RFC assessments that indicate a capacity for unskilled work—or even for more than unskilled work—are meaningless. Such RFCs become important when the claimant also has a physical RFC. (See Section C, below.)

A mental RFC contains four areas of function to be assessed, covered in Sections 1 through 4, below. These include the basic abilities needed for any job. The limitation assigned to each area is a matter of medical judgment, derived from the evidence. If any one area is assessed as markedly limited, the claimant will be considered unable to do even unskilled work. If the RFC contains various combinations of moderately limited and not significantly limited ratings, the DDS examiner or vocational analyst, ALJ, or federal court judge (depending on who has the claim) will have to determine whether the claimant can return to prior or other work. This is not the job of a doctor, such as a DDS medical consultant, because most doctors are not experts in vocational (job-related) issues. The vocational application of RFCs is discussed in Chapter 9.

1. Understanding and Memory

The SSA evaluates the following areas of understanding and memory function:

- remembering locations and work-like procedures—if markedly limited, you cannot perform unskilled work
- understanding and remembering very short and simple instructions—if markedly limited, you cannot perform unskilled work
- understanding and remembering detailed instructions—if markedly limited, you cannot perform semiskilled or skilled work.

2. Sustained Concentration and Persistence

The SSA evaluates your ability to do the following related to concentration and persistence:

- carry out very short and simple instructions—if markedly limited, you cannot perform unskilled work
- carry out detailed instructions—if markedly limited, you cannot perform semiskilled or skilled work
- maintain attention and concentration for extended periods—if markedly limited, you cannot perform unskilled work
- perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances—if markedly limited, you cannot perform unskilled work
- sustain an ordinary routine without special supervision—if markedly limited, you cannot perform unskilled work
- work in coordination with or proximity to others without being unduly distracted by them—if markedly limited, you cannot perform unskilled work
- make simple work-related decisions—if markedly limited, you cannot perform unskilled work, and
- complete a normal workday and workweek without interruptions caused by mental symptoms and perform at a consistent pace without an unreasonable number and length of rest periods—if markedly limited, you cannot perform unskilled work.

3. Social Interaction

The SSA evaluates your ability to sustain the following social interactions:

- interact appropriately with the general public—no general rule can be given for limiting this area because jobs vary so greatly
- ask simple questions or request assistance—if markedly limited, you cannot perform unskilled work
- accept instructions and respond appropriately to criticism from supervisors—if markedly limited, you cannot perform unskilled work
- get along with coworkers or peers without distracting them or exhibiting behavioral extremes—if markedly limited, you cannot perform unskilled work, and
- maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness—no general rule can be given for limiting this area because jobs vary so greatly.

4. Adaptation

Finally, the SSA evaluates your ability to do the following regarding adaptation:

- respond appropriately to changes in the work setting—if markedly limited, you cannot perform unskilled work
- be aware of normal hazards and take appropriate precautions—if markedly limited, you cannot perform unskilled work
- travel in unfamiliar places or use public transportation—no general rule can be given for limiting this area because jobs vary so greatly, and
- set realistic goals or make plans independently of others—if markedly limited, you cannot perform semiskilled or skilled work.

5. Statements of Your Treating Physician

The SSA is supposed to accept your treating doctor's opinion regarding your functional abilities, if that opinion is consistent with the evidence in your file. If the SSA does not accept that opinion, the RFC must contain a careful explanation of the conclusions that differ from the treating source's conclusions or your allegations.

In addition to the RFC rating areas described in Section B, the DDS mental consultant must complete what is called a Psychiatric Review Technique Form (PRTF). This document is based on diagnostic categories of mental disorders and is supposed to serve as sort of a checklist to help the person assessing the mental RFC (such as a DDS psychologist or psychiatrist or an ALJ) be sure he has considered all relevant medical evidence. Possible improper completion of the mental RFC or PRTF are something you or your authorized representative should look for if reviewing your file and planning an appeal (see Chapters 6 and 12).

Especially look for opinions expressed on these documents that are not backed up by evidence in the file.

C. Claims With Both Physical and Mental RFCs

As pointed out in Section B, because of the large numbers of unskilled jobs in the economy, it is very rare for a claimant with a purely mental impairment who is capable of unskilled work to be granted benefits. In fact, the medical-vocational rules in Appendix C always require claimants to have significant physical impairments (those that require a physical RFC) for allowance of a claim. Of course, if you have a mental RFC for less than unskilled work your claim will be allowed without any need of the SSA to consider any physical impairments you might have or the medical-vocational rules. Many claimants have both mental and physical impairments requiring RFCs. In these cases, depending on the claimant's vocational factors, an allowance of benefits may be possible if the claimant is capable of semiskilled, or even skilled, work. This means that a mental RFC for more than unskilled work can result in allowance. ■

Chapter 9

How Age, Education and Work Experience Matter

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If you have a significant impairment, but one not severe enough to meet or equal an entry on the Listing of Impairments, the SSA will determine what abilities you do have (known as residual functional capacity, or RFC) to see if you can return to your *past* work. If you cannot, the SSA will then consider your age, education and work experience—called the vocational factors—to determine if you can do *any* work. If you cannot, you will be considered disabled.

The SSA has published tables that consider RFC ratings along with age, education and work experience. The tables direct the SSA to find someone “disabled” or “not disabled,” depending where the person falls. The tables are known as the medical-vocational rules or, more informally, the medical-vocational guidelines or grid. They appear in Appendix C along with instructions on how to use them. If you fall into a disabled grid in the medical-vocational guidelines, the SSA will consider you to be a *medical-vocational allowance*, which means you will be awarded disability.

Table 1 considers sedentary work RFCs with vocational factors; Table 2 deals with light work RFCs and Table 3 with medium work RFCs. Heavy work RFCs are not linked with medical-vocational rules because they essentially are considered the same as a not severe (slight) impairment that does not produce any significant limitation in physical ability; thus the SSA would find a claimant capable of doing heavy work not disabled.

Turn to the Appendix and look at Table 1. You can see that nine medical-vocational rules result in allowance when vocational factors are combined with sedentary RFCs. These are: 201.01, 201.02, 201.04, 201.06, 201.09, 201.10, 201.12, 201.14 and 201.17. Now turn to Table 2. Five medical-vocational rules result in allowance for claimants with light RFCs. These are: 202.01, 202.02, 202.04, 202.06 and 202.09. Finally, look at Table 3. Now you see that only three medical-vocational rules result in allowance for claimants with medium RFCs. These are: 203.01, 203.02 and 203.10. This makes sense, given that being able to tolerate medium work means there's a greater chance that there's some job you could do.

How age, education and work experience are evaluated under the medical-vocational rules is considered below. This material will be clearer to you if you refer to the tables in Appendix C.

A. Age

Your application for disability will be evaluated under one of the following categories:

- under 50 years (younger individuals)
- age 50–54 years (closely approaching advanced age)
- age 55–59 years (advanced age)
- age 60–64 (advanced age and also closely approaching retirement age).

Age is an important vocational factor affecting your ability to adapt to new work situations and to compete with other people. The lower your RFC at a particular age, the greater chance you will be found disabled under a medical-vocational rule. And the older you are, the greater the chance you will be found disabled with a particular RFC. In other words, a 55-year-old claimant with a sedentary RFC has a better chance of being allowed than if he had an RFC for light, medium or heavy work. Similarly, a 55-year-old claimant with a sedentary RFC has a better chance of being allowed under the rules than a 25-year-old with the same RFC.

1. Sedentary Work and Age

Claimants 55 years of age and older are especially likely to be found disabled under a medical-vocational rule for disability when they have RFCs for sedentary work. As Table 1 shows, the only “not disabled” claimants of this age group are those with past skilled or semiskilled work experience whose skills can be transferred to new jobs or whose education permits them to do skilled work. Also, to be found “not disabled” in this age group, Table 1 requires claimants to be able to do a new job with little or no adjustment in their tools, work processes, work settings or industry. In other words, to be 55 or older and denied benefits with a sedentary RFC, claimants would have to fit into a job with little difficulty and perform the work as if they had been doing it for years. The same rules apply for claimants 50–54 years old with a sedentary RFC.

What about claimants under age 50 with a sedentary RFC? As Table 1 shows, these claimants will have a much harder time being granted a medical-vocational allowance. If you are 45–49, you can be found

disabled with a sedentary RFC under rule 201.17 if all of the following are true:

- you are unskilled and have no skills that can be transferred to a new job
- you have no past work that is relevant to your current ability to work or you can no longer perform your past work, and
- you are either illiterate or unable to communicate in English.

If you are between 18 and 44, under the SSA's rules, you will not be granted disability with a sedentary RFC.

2. Less Than Sedentary Work and Age

RFCs for less than sedentary work are not part of the medical-vocational rules, but such an RFC will almost always result in allowance of benefits at any age, regardless of education and past work experience. Less than sedentary RFCs are discussed in Chapter 8, Section A1.

3. Other Work Levels and Age

If you are in the 60–64 age range, you will be found disabled under the medical-vocational rules of Table 1 for sedentary work and Table 2 for light work, unless you have highly marketable skills. Note also on Table 2 that many claimants ages 55–59 are allowed benefits with RFCs for light work or less.

In general, few claimants are found disabled with an RFC for medium work, however; claimants 55 or older may be found disabled if they have a limited education and a history of no past work or of unskilled work. See Table 3, medical-vocational rules 203.01, 203.02 and 203.10.

4. Age Examples

Age 55 is frequently the threshold that separates allowance and denial of disability benefits. Two examples demonstrate this fact, as well as how allowance or denial can turn on fine points.

EXAMPLE 1: Rita is 54 years old, has moderate arthritis in her spine so that she can't do more than light lifting, and receives an RFC for light work. But she has a college degree and has done desk work most of her life. The SSA will deny her claim. If she has skills that could be transferred to another job, she'll be denied benefits under medical-vocational rule 202.15. Even if she doesn't have any transferable skills, she'll still be denied benefits under medical-vocational rule 202.14.

EXAMPLE 2: Lou is just a year older, 55, and has moderate arthritis in his spine so that he can't do more than light lifting. If he has skills that can be transferred to another job, he will be denied benefits under medical-vocational rule 202.07. If he doesn't have transferable skills, he might be denied benefits under medical-vocational rule 202.08—but only if he can do other skilled work specified by the SSA without further training. If he doesn't have transferable skills and can't do other skilled work without training, then he will be granted benefits under medical-vocational rule 202.06.

B. Education

Education means formal schooling or other training that contributes to your ability to meet vocational requirements—for example, reasoning ability, communication skills and arithmetic skills. Lack of formal schooling does not necessarily mean that you are uneducated or don't have these abilities. You may have acquired meaningful work skills through job experience, on the job training or other means that did not involve formal school learning. Past work experience and work responsibilities may show that you have intellectual abilities, although you may have little formal education. In addition, your daily activities, hobbies or test results may show that you have significant intellectual ability that can be used for work.

1. How the SSA Evaluates Education

How much weight the SSA places on education may depend upon how much time has passed between the completion of your education and the onset of your impairments, and on what you have done with your education in work and other settings. The SSA knows that formal education completed many years ago may no longer be meaningful in terms of your ability to work. This is especially true regarding skills and knowledge that were a part of your formal education, but which you haven't used in a very long time. Therefore, the numerical grade level you completed may not represent your actual educational level, which could be higher or lower. But if the SSA has no evidence to show that your actual education differs from your grade level, the SSA will use your numerical grade level to determine your educational abilities.

When you file your application for disability benefits, you will be asked about your education. The SSA will accept your word about your educational level, unless you've given them some reason to doubt it—such as being a certified public accountant and saying you never completed the fifth grade. If you have any additional or written documentation about your education that you want in your file, give it to your SSA Field Office and someone there will send it to the DDS; or you could send it to the examiner at the DDS handling your claim.

The effect of your education on your ability to work is evaluated in the following categories:

Illiteracy. Illiteracy means the inability to read or write. The SSA considers someone illiterate if the person cannot read or write a simple message such as instructions or inventory lists, even though the person can sign his or her name.

Marginal education. Marginal education means sufficient ability in reasoning, arithmetic and language skills to do simple, unskilled types of jobs. The SSA generally considers formal schooling to the sixth grade or lower to be a marginal education.

Limited education. Limited education means some ability in reasoning, arithmetic and language skills, but not enough to allow a person to do most of the complex job duties needed in semiskilled or skilled jobs. The SSA generally considers a formal education

that ended somewhere between seventh and eleventh grade to be a limited education.

High school education and above. High school education and above means abilities in reasoning, arithmetic and language skills acquired through formal schooling that included completing high school and may have included more education. The SSA generally considers someone with these educational abilities able to do semiskilled through skilled work.

Note that the SSA also generally considers a claimant's ability to communicate in English. Because the ability to speak, read and understand English is generally learned or increased at school, the SSA often considers this as part of the educational factors. Because English is the dominant language of this country, someone who doesn't speak and understand English may have difficulty doing a job, regardless of the education achieved in another language.

2. Education and Medical-Vocational Rule Tables

Your education is an important vocational factor because it relates to the types of mental skills that you may be able to bring to a job. Turn again to Appendix C to see how various educational levels at sedentary, light and medium work affect the allowance or denial of a claim. Under each table, lower educational levels make allowance of benefits more likely. This is particularly true as age increases and work experience and skills decrease.

A high school education or above is a critical threshold, and greatly decreases your chance of being allowed benefits, although it does not eliminate them entirely. If you have a high school education or more, your education doesn't provide you with any skills you can easily use in a job, you have a history of unskilled or no work, you are at least 55 years old and you have a sedentary RFC, you would be disabled under medical-vocational Rule 201.04 (Table 1). With the same findings and an RFC for light work, you would be disabled under Rule 202.04 (Table 2). With the same findings and a medium RFC, however, you would be denied under Rule 203.14 (Table 3). In fact, a high school education and a medium RFC could get you denied even as old as age 64 (rule 203.06).

With a limited education, your chance of being found disabled greatly increases. As you can see on Table 1, if you have a sedentary RFC, your education is limited or less and you are at least 50 years old with a history of no work or only unskilled work, you will be allowed under medical-vocational Rule 201.09. If you have skilled work abilities that can't be transferred to a new job, you would be allowed under Rule 201.10.

If you are at least age 55 with limited education and an RFC for light work and you have no or unskilled work experience, you could be allowed under Rule 202.01. With the same age and education, even if you have experience with semiskilled or skilled work, you could still be allowed under Rule 202.02, provided your skills can't be transferred to a new job. If you have a light RFC and are at least 50 years old, you can be allowed under Rule 202.09, provided that you are illiterate and have no work history, or only did unskilled work.

3. Education Examples

Two examples help illustrate the rules discussed above.

EXAMPLE 1: Dom has only a third grade education, has done no work his entire life, is 55 years old and has an RFC for medium work because of intermittent back pains and age-related degenerative changes in his spine. Medium work means Dom can lift up to 50 pounds and stand six to eight hours a day. That's more physical ability than many healthy people have. Yet Dom is going to be allowed SSI benefits under medical-vocational Rule 203.10 because his chance of finding a job that he is qualified to perform is small. (See Table 3 in Appendix C.)

EXAMPLE 2: Chuck is also age 55, has a high school education, has worked in semiskilled jobs and has paid Social Security taxes throughout his life. He also has occasional back pains and age-related degenerative changes in his spine, and his RFC rating that says the most he can do is medium work. His claim for SSDI may be denied under medical-vocational Rules 203.15, 203.16 or 203.17

because his education will supposedly enable him to perform some type of work. Even if he has never worked, he could be denied under medical-vocational Rule 203.14 because of his education.

C. Work Experience

"Work experience" means the skills you have acquired through work you have done and indicates the type of work you may be expected to do. Your work experience should be relevant to your ability to perform some type of currently existing job.

The SSA has three considerations in deciding whether your past work experience is relevant.

1. The SSA recognizes that the skills required for most jobs change after 15 years. Therefore, the general SSA rule is that any work you did 15 or more years before applying for disability is not relevant to your current job skills. If you are applying for SSDI and your "date last insured" (DLI) is earlier than the application date, the SSA applies the 15-year rule described above to the DLI. The DLI is the date at which your eligibility for SSDI benefits ran out, usually because you stopped working. After your DLI you can still sometimes receive benefits if you became disabled before your DLI.
2. Your work experience must have lasted long enough for you to acquire actual experience.
3. Your work must have been substantial gainful activity. (See Chapter 1, Section B1.)

1. Information About Your Work

If your impairment is significant but does not meet or equal a listing, the SSA will ask you about the work you have done in the past. If you cannot give the SSA all the information it needs, the SSA will try, with your permission, to get it from your employer or another person who knows about your work, such as a relative or a co-worker. When the SSA needs to decide if you can do work that is different from what you have done in the past, you will be asked to tell the SSA about all of the jobs you have had during the past 15 years.

You must tell the SSA the dates you worked, your duties and the tools, machinery and equipment you used. You also need to tell the SSA about the amount of walking, standing, sitting, lifting and carrying you did during the work day, as well as any other physical or mental duties of your job.

2. Work in the National Economy

If the SSA denies your claim, saying you can perform a particular type of work, it means that the SSA believes there are significant numbers of jobs open for doing similar work in the national economy. "Significant numbers" is not an exact number; it is only meant to ensure that there is a reasonable chance that such work would be available. In other words, the SSA will not deny you benefits by referring to jobs that are isolated and exist in very limited numbers in relatively few locations. The SSA does not have to refer to a particular location in the country where you might find a job, however.

a. How the SSA Finds Job Information

The SSA must refer to reliable job information before saying there are jobs in the national economy that you can do. While the SSA looks at statistics from state employment agencies, the Bureau of Labor Statistics and the Census Bureau, the SSA relies most heavily on the Department of Labor's *Dictionary of Occupational Titles (DOT)*.

You can refer to the *DOT* yourself. It's a big book—nearly 1,500 pages—and can be purchased from the U.S. Government Printing Office (www.gpo.gov). It's available in most large public libraries, law libraries, university libraries and on the Internet at www.oalj.dol.gov/libdot.htm; but soon to be replaced by the O*NET, at www.doleta.gov/programs/onet. Also, the DDS should have a copy to let you look at—just ask your claims examiner.

The *DOT* lists various jobs, along with the physical and mental abilities required, and the amount of education needed. An important consideration is the *specific vocational preparation*, or SVP. The SVP is expressed as a number (the lower the number the less skill needed) and is the amount of time required to

learn the techniques, acquire information and develop the quickness needed for average performance in a specific job. The examiner or vocational analyst working on your claim will refer to the *DOT* to determine your SVP. With the SVP, the examiner or vocational analyst can find out the skill level required in your past work experience, which is important when looking at the medical-vocational rules.

b. Factors Not Considered in SSA's Work Decision

When the SSA decides there is work you can perform, the following factors do not matter.

- your inability to get work
- the lack of work in your local area
- the hiring practices of employers
- technological changes in the industry in which you have worked
- changing economic conditions
- that there are no job openings for you
- that an employer might not hire you, even if you are capable of doing the work, and
- that you do not wish to do a particular type of work.

3. Skill Requirements for Work

Certain mental abilities (skills) are necessary to perform various kinds of work. Abilities needed for the most basic, unskilled kinds of work are simply a part of normal human ability and do not require any advanced education or even work experience. More advanced skills can be obtained by work experience and education. The three levels of skills considered by the SSA are unskilled, semiskilled and skilled.

a. Unskilled Work

Unskilled work is work that needs little or no judgment. It involves simple tasks that can be learned on the job in a short period of time. The job may or may not require considerable strength. The SSA considers a job unskilled if the primary work duties are handling materials, placing or removing materials into or from automatic machines or machines operated by

others or machine tending, if the job can be learned in 30 days, and if little specific job-skill preparation and judgment are needed. A person does not gain work skills by doing unskilled jobs.

Some examples of unskilled jobs are farmhand, garbage collector, maid and delivery person. Determining whether work experience is unskilled is not always simple, because some unskilled jobs may require abilities in common with semiskilled work. For example, a delivery person may be required to provide summaries and reports of her daily delivery route.

The basic mental abilities needed to perform unskilled work are those required to perform even the simplest job. If you have a mental impairment, your abilities are rated on a mental RFC (see Chapter 8, Section 2). If you have no significant mental impairment, the SSA will assume that there is no significant limitation in your ability to perform unskilled work.

Jobs listed in the *DOT* with an SVP of 1 or 2 are considered to be unskilled work.

There are several important special concepts and considerations about unskilled work that can influence your claim—"less than unskilled work," "unskilled work and mental disorders" and "work that has been arduous and unskilled." Each of these are discussed below.

Less than unskilled work. If you can't meet the basic mental demands for unskilled work, you can be found disabled regardless of your age, education or work experience. The SSA looks for whether you've had a "substantial loss" of abilities. The SSA does not exactly define substantial loss, but it is similar to the marked limitation on a mental RFC discussed in Chapter 8. Moderate limitations in multiple unskilled abilities on a mental RFC might be enough for an allowance, but the vocational analyst would have to apply his judgment to determine if there was work you could do.

Just as there are no medical-vocational rules for a less than sedentary physical RFC, there are no medical-vocational rules for a less than unskilled work mental RFC. Because these are below the lowest medical-vocational vocational rule classification, they strongly suggest that the claimant should have met or equaled a listing and that an RFC was never needed in the first place.

Why is this a category then? The answer is that not everyone in the SSA who reviews disability claims does

things exactly right in regard to the "coding" of a claim—that is, how the allowance is classified as qualifying under a listing or as an RFC resulting in a medical-vocational allowance. For example, a psychiatrist or psychologist reviewing a mental impairment claim at a DDS might determine that one or more of the abilities needed to do unskilled work is markedly limited on a mental RFC they are completing. As discussed in Chapter 8, this will always lead to a medical-vocational allowance. At this point, the consultant should say to themselves, "I should go back and code this case to meet or equal a listing." Instead, they might just go ahead and leave the mental RFC in such a way that the examiner or vocational analyst will be forced to allow the claim on a medical-vocational basis. It is not that the consultant is doing the vocational determination in deciding the claim has to be allowed with certain medical restrictions—it's just that the consultant knows what the outcome will have to be in these instances. Unfortunately, some consultants try to get around the requirements of a listing by manipulating a mental RFC in a way they know will force the examiner or vocational analyst to allow it on a medical-vocational basis. In these cases they're guessing and doing sloppy work rather than getting the detailed medical information necessary. Use of "less than unskilled mental RFCs" is a common enough practice by some DDSs (and administrative law judges) that you should know about it.

Unskilled work and mental disorders. What if a claimant has a significant mental disorder and a mental RFC, but no significant physical disorder? How does the SSA rate these claims, given that the medical-vocational rules involve a physical RFC? Any claimant with a mental impairment who can do unskilled work will almost always be denied benefits. There are many unskilled jobs with no physical exertional restrictions to which the SSA can refer a claimant.

In a few rare instances, a claimant might be considered disabled with a mental impairment and the ability to do unskilled work. These are cases in which the claimant is close to retirement age, has no more than a limited education and has essentially spent her lifetime in an unskilled job that she cannot now do because of her mental impairment. Of course, these are claimants who do not meet or equal a listing, but receive a mental RFC for unskilled work.

Work that has been arduous and unskilled. It is important for the SSA to recognize claimants who have performed only arduous, unskilled work for many years. These people are often granted benefits because the SSA often cannot refer to jobs that they could perform, once they can no longer do their past work. Arduous work has three elements.

- It is primarily physical work requiring a high level of strength or endurance.
- It usually involves physical demands that are classified as heavy.
- If it does not have heavy demands, then it requires a great deal of stamina or activity such as bending and lifting at a very fast pace.

If all of your work in the past 15 years has been arduous and unskilled and you have very little education, the SSA will ask you about all of your jobs from when you first began working. This information could help you to get disability benefits because the SSA might decide that you cannot do lighter work. Specifically, SSA regulations provide that you will be found disabled if:

- you have only a marginal education
- you have 35 years or more work experience during which you did arduous unskilled physical labor
- you are not currently working, and
- you are no longer capable of arduous work because of your impairment (an RFC for medium work or less).

EXAMPLE: Mr. B is a 60-year-old miner with a fourth grade education who has a lifelong history of arduous physical labor. Mr. B has arthritis of the spine, hips and knees, and other impairments. Medical evidence establishes that these impairments prevent Mr. B from performing his usual work or any other type of arduous physical labor. Although his disability is not severe enough for him to meet or equal a listing, his job history shows he does not have the skills or capabilities need to do lighter work. Under these circumstances, the SSA will find Mr. B disabled on a medical-vocational basis.

b. Semiskilled Work

Semiskilled work requires some skills, but does not include complex work duties. Semiskilled jobs may require alertness and close attention to watching machine processes; inspecting, testing or looking for irregularities; tending to or guarding equipment, property, materials or persons against loss, damage or injury; or other types of activities. A job may be classified as semiskilled where coordination and dexterity are necessary, such as when hands or feet must be moved quickly to do repetitive tasks.

Semiskilled jobs include quality control inspector, typist, receptionist, security guard, truck driver and secretary. Some semiskilled jobs have elements of skilled work in them, which means that determining if work experience is semiskilled or skilled is not always simple.

Jobs listed in the *DOT* with an SVP of 3 or 4 are considered to be semiskilled work.

c. Skilled Work

Skilled work requires judgment to determine the equipment to use and operations to be performed in order to obtain the proper form, quality or quantity of material to be produced. Skilled work may require laying out work, estimating quality, determining the suitability and needed quantities of materials; making precise measurements; reading blueprints or other specifications; or making necessary computations or mechanical adjustments to control or regulate the work. Other skilled jobs may require dealing with people, facts, figures or abstract ideas at a high level of complexity.

Examples of skilled jobs include engineer, doctor, pilot, accountant, attorney and architect. Skilled work, however, is not confined to people who have college and advanced degrees. Machinists perform skilled work, and some assembly-line work is considered skilled. Computer programmers, mechanics working on today's highly specialized automobiles, many types of electronic technicians and numerous other skilled jobs don't necessarily require a college degree.

Jobs listed in the *DOT* with an SVP of 5 or higher are considered to be skilled work.

d. Transferable Skills

The SSA will not award you disability just because you can't do your former jobs. If you can't do jobs you previously held because your RFC is for work lower than you used to do, then the SSA will look into whether you have *transferable skills* from your past work that you could use for other work. This issue is an important part of the medical-vocational analysis. If your skills can be usefully transferred, then you will be denied benefits. If they can't, you may still get benefits as a "medical-vocational allowance," depending on your RFC and other vocational factors. Note that whether you have transferable skills concerns only semiskilled and skilled work—because unskilled work does not produce work skills, there is nothing to transfer.

The SSA considers the transferability of skills most meaningful between jobs in which all of the following are true:

- the same or a lesser degree of skill is required
- the same or similar tools and machines are used, and
- the same or similar raw materials, products, processes or services are involved.

The degree of transferability of skills ranges from very close similarities to remote and incidental similarities. A complete similarity of the three above factors is not necessary for the SSA to consider you to have transferable skills. When skills are so specialized or have been acquired in such an isolated work setting (like many jobs in mining, agriculture and fishing) and are not readily usable in other jobs, however, the SSA considers that they are not transferable.

D. Use of Vocational Analysts

The medical-vocational rules in Appendix C can help you figure out if you are likely to be considered disabled or not disabled on a medical-vocational basis. Remember from Chapter 8, however, that these rules will be applied exactly as written only if your RFC rating has no special restrictions. With special restrictions, the SSA must decide based on your individual circumstances, within the framework of the rules.

Vocational analysts are people with expert training in how a person's vocational factors influence her ability to perform various kinds of jobs. In the DDS, vocational analysts handle complex issues when RFCs or vocational factors do not exactly fit into the medical-vocational rules. At the hearing level, the administrative law judge, in reaching a decision, often uses the opinion of vocational analysts. At this level, the analysts do not work for the DDS but are private consultants under contract with the Office of Hearings and Appeals.

EXAMPLE: MaryEllen has lung disease and arthritis, neither of which is severe enough to meet or equal a listing. Regarding her lung disease, MaryEllen's RFC specifies that she do no more than light work and avoid exposure to excessive dust and fumes. Because of her arthritis, MaryEllen cannot use her hands to perform certain kinds of functions such as fine manipulations or pinching. Such a complex RFC would require a vocational analyst before fairly judging this claim.

Make Sure Your File Has Vocational Details

The devil is in the details. Not all SSA examiners are conscientious about getting vocational details from claimants about their prior work experience and skills, and a vocational analyst can work only with the information he has. If you needed any special consideration to perform your past work, make sure everyone at the SSA handling your claim is aware of that fact. Also, some medical consultants do not include important details on the RFC form for the vocational analyst. For example, you might have done a particular sewing job for many years and can do only jobs requiring similar skills. But you have arthritis in your thumb joint because of the repetitive movement required by the job. The medical consultant fails to note that you can't do work requiring frequent and repetitive thumb movement, although he restricts you to light work. The vocational analyst gets your claim, and because your prior work was less than light, sends you right back to the very thing you can't do.

To see the RFC in your file and make sure it has all the necessary information, see Chapter 2, Section E. It is possible to make sure the important medical details are considered in your RFC without all the hassle of seeing your file. Call your claims examiner and ask whether your RFC considers all of your medical limitations. Review every impairment you have. Be specific in your questions—using the above example, MaryEllen should ask if the RFC limits her use of her thumb. If you have lung disease, make sure your RFC restricts you from excessive exposure to dust and fumes; if you have epilepsy, your RFC should restrict you from working at unprotected heights or around hazardous machinery; if your back pain is so severe you can't bend over, your RFC should restrict your bending.

If the examiner says that an important work-related limitation was not addressed on your RFC, ask the examiner to return the RFC to the medical consultant who prepared it to correct the oversight. If the examiner states that your treating doctor's medical records don't show a problem or otherwise don't address your concern, insist that you do have a problem and you want it evaluated before your claim is decided. Ask to speak to the examiner's supervisor and, if necessary, call the DDS director. Federal laws and regulations require that every one of your complaints be fully addressed by the SSA.

If the problem is your treating doctor, ask the examiner to hold your file until you can contact your doctor and find out why your medical records are incomplete. You will probably get full cooperation from your doctor. If you don't, you must insist to the examiner that you have a problem and want it evaluated. This will almost invariably result in the DDS ordering another doctor to evaluate you. If your claim is at the hearing level and your file doesn't contain information on all of your problems, tell the administrative law judge that you have a problem that was not addressed by the DDS when it denied your claim.

E. Vocational Rehabilitation

Vocational rehabilitation (VR) is the process of restoring a disabled person to the fullest physical, mental, vocational and economical usefulness of which he or

she is capable. The SSA refers some SSDI and SSI claimants to vocational rehabilitation.

Vocational rehabilitation is a public program administered by a VR agency in each state to help people with physical or mental disabilities to become gainfully employed. A rehabilitation counselor evaluates your vocational disability, based on medical and vocational findings, to determine your eligibility for services. If you are eligible for services, the counselor will work with you to plan a program of rehabilitation.

1. Good Cause for Not Attending Vocational Rehabilitation

If you are referred to VR and refuse to attend, the SSA can deny you your disability benefits, unless you have good cause for failing to attend. If a problem makes it difficult for you to attend VR, try to find a solution with the state VR agency so you can attend. If you can't work out a solution, the SSA will decide if you have good cause for not attending. You cannot decide that for yourself.

Under the following situations, the SSA might find good cause for failing to attend VR:

- The services offered are not designed to restore your ability to work.
- You are already in a public or private program designed to restore your ability to work.
- You already attend school, college or university, or participate in vocational or technical training designed to restore your ability to work. (This must be documented by you, the VR agency or the SSA, along with a description of the course of study, number of credit hours required, number earned and grade point average.)
- You are physically or mentally unable to participate in the services offered. (This must be documented by your treating physician and the SSA.)
- Your educational or language limitations hinder your participation in the services offered.
- The offered services would interfere with a medical program you are undergoing. (This must be documented by your treating physician.)

- The services would require you to be away from home and such absence would be harmful to the health and welfare of your family. (This must be documented by your family physician.)
- You work or will be working within three months. (This must be documented by a copy of a pay stub or a statement from your prospective employer.)
- You are a member or follower of a recognized religious sect that teaches reliance solely on prayer or other spiritual means for the treatment of any physical or mental illness and your VR services include medical treatment.

2. Criteria for Not Being Referred to Vocational Rehabilitation

The SSA will not refer certain claimants to a state VR agency. This includes claimants who have the following:

- an illness in terminal state—irreversible or irremediable

- a physical or mental impairment so severe that work adjustment, training or employment would be precluded
- chronic brain syndrome with marked loss of memory and understanding
- a long-standing neurological or psychiatric impairment not responding to treatment, substantiated by poor employment or poor social history
- advanced age with impairment of such severity that potential to adjust to or sustain work is doubtful
- advanced age (usually over age 55) with a significant impairment and either a sparse work record or a record of performing arduous unskilled labor for at least 35 years, having a marginal education with no transferable skills, or
- an age of under 15, unless the claimant's circumstances indicate a readiness to begin VR services. ■

Chapter 10

When Benefits Begin

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The Social Security system uses the term “onset” to refer to the date you became disabled. This date is important because the SSA may pay you SSDI benefits retroactively to the date you were disabled, even if you don’t apply for disability until later. (The SSA does not pay SSI benefits until the first day of the month following the date of your application.) Not surprisingly, however, the date of onset isn’t always clear and can be influenced by medical and nonmedical factors.

Actually, there are three different onset dates.

Alleged onset date (AOD). This is the date you state on your disability application that you became unable to work due to your impairment. If the SSA states that your impairment was not disabling at the AOD, the SSA must have *contrary evidence* to disregard your AOD and select another date.

Medical onset date (MOD). This is the date your impairment is medically severe enough to find you disabled. In some cases, this is the same date as your AOD. But the MOD is not necessarily the same date you become eligible for disability benefits, because you must also meet nonmedical eligibility factors to qualify for the benefits.

Established onset date (EOD). This is the date that the SSA finds you became eligible to receive disability benefits. All of the following must be true:

- your impairment must be sufficiently severe to qualify you for disability
- you must have satisfied the nonmedical eligibility factors
- you cannot be engaged in a Substantial Gainful Activity (see Chapter 1, Section B), and
- your impairment is expected to last at least 12 months or result in your death.

The EOD is the onset date used by the SSA, and may or may not be the same as the AOD or MOD. Three primary factors affect your onset date (EOD)—medical evidence about your condition, your work experience and whether you are applying for SSDI or SSI.

A. Medical Evidence

Medical evidence serves as the primary element in onset determination. The SSA should review reports from all medical sources that bear upon the onset

date to determine when your impairment became disabling. The EOD must be consistent with the medical evidence in your record. If the SSA is unable to obtain sufficiently detailed medical reports from your treating doctors or hospitals, you may not get an onset date as early as you deserve. See Chapter 5 for information on how to get good evidence into your file.

B. Work Experience

The date you stopped Substantial Gainful Activity (SGA) is an important one for establishing your EOD if you are applying for SSDI. If the medical evidence shows that you were disabled before you stopped working, the SSA is likely to set your EOD at the date your SGA ended. Determining when your SGA stopped is not necessarily clear-cut.

In deciding whether your work is Substantial Gainful Activity, the SSA considers the nature of your duties, your hours worked, your productivity, your pay and any other factors related to the value of the services your work provided. Usually, the best gauge of whether your work is considered SGA is the amount of pay you received. Under current Social Security regulations, any work that averages more than \$800 a month is considered SGA. (If you are blind, the amount is \$1,330 and is adjusted annually.) If your employer had to provide special help for you to work, the value of the special assistance may be considered a subsidy and subtracted from your earnings. Additionally, impairment-related work expenses you must pay are deducted from your earnings. This means that if you were working but not doing SGA, the SSA may find your EOD to be a date while you were still employed.

EXAMPLE 1: When Caesar injured his back, he could no longer carry the heavy loads that his construction job required. His employer allowed his co-workers to do the heavy lifting and carrying for him. Six months after his injury, he applied for SSDI benefits. When he was working he earned \$850 per month, but the SSA deducted \$250 per month because special considerations were provided by his boss that he had to have in order to perform the job. Therefore, Caesar really earned

only \$600 per month, below the SGA level. The SSA found his EOD to be the date he injured his back.

EXAMPLE 2: Suyan, a blind medical consultant, was hit by a truck and paralyzed. A month later, she applied for SSDI disability benefits. Before her paralysis, Suyan could do her job only with special considerations. Other medical consultants did part of the medical work for her, such as reading medical graphs, charts and tracings. In addition, others read files to her, escorted her to business meetings and recorded documents on audio tape for her to listen to. She could not take notes in meetings or see films or slides. She could not work with computers, complete medical forms or read what she signed. Her employer estimated that the value of her special considerations was at least \$5,000 per month, or \$56,000 yearly. But Suyan's annual salary was \$100,000, way over the SGA level, even with the \$56,000 deduction. Therefore, Suyan's EOD could not be earlier than the date of her paralysis.

C. SSDI or SSI Claimant

The SSA distinguishes between the onset dates in SSDI claims and SSI claims. If you apply for both SSDI and SSI at the same time based on the same impairment, these concurrent claims may have different onset dates.

1. SSDI Claimants

If you are an SSDI claimant, you may be entitled to retroactive (past) benefits if the SSA finds that your EOD fell on a date earlier than your application date. Even if the SSA makes such a finding, however, the SSA will not automatically pay you benefits from your EOD. The SSA requires that at least five full calendar months, known as the *waiting period*, pass beyond your EOD before you get any benefits.

Once the SSA establishes your EOD, it waits until the first day of the following month (unless your EOD

is on the first of the month), and then counts an additional five months to determine the date you are eligible for benefits. For example, if your EOD is March 2, the SSA doesn't count March as a part of your waiting period. Instead, your waiting period is made up of April, May, June, July and August. If you apply for benefits any time after September 1, the SSA will pay them retroactively to September 1—assuming you qualify for benefits.

If you otherwise qualify, the SSA may establish an EOD as far back as 17 months before you apply for benefits, and then count the five-month waiting period. What this means, essentially, is that if you apply for SSDI well after becoming disabled, the SSA will not pay you retroactive benefits for more than 12 months. This is a requirement of federal law, so even if a doctor at the SSA states that you satisfied the medical severity requirements many years in the past, you still cannot have an earlier EOD.

To get maximum retroactive benefits of a full 12 months, you need to have an EOD that causes the 17th month before your application to be counted as a waiting period month. To accomplish this, the EOD must be no later than the first day of the 17th month before your application. Any medical onset date of 18 or more months before the application date would have the same effect, because the SSA would then set the EOD the earliest it can legally be, which would be the first day of the following month—the 17th month.

EXAMPLE: Jerry, a 57-year-old bricklayer and long-time cigarette smoker, stopped working July 2, 2001—two years before applying for SSDI on July 1st, 2003. He states that he had to stop work because of shortness of breath, and had been financially supported by his children until recently. His medical records confirm lung disease and markedly decreased breathing capacity associated with emphysema. Based on the evidence, Jerry's medical condition is severe enough to qualify for benefits when he stopped working two years previously, and the DDS medical consultant reviewing Jerry's claim states he could have a medical onset all the way back to July 2, 2001. However, knowing that an onset 17 full months before the application date is the most the claimant can have under law, the examiner handling

Jerry's claim then establishes the onset for disability purposes as March 1, 2002. This effectively gets rid of Jerry's five-month waiting period for SSDI claimants and gives him the full 12 months of benefits before his application date that is permissible under law. (Note that Jerry loses the benefits he could have had between July 2, 2001, and March 1, 2002, because he didn't apply soon enough—the fact that his children were helping him with living expenses would not have disqualified him for SSDI benefits.)

There are two exceptions to the waiting period rule. First, if you were approved for SSDI benefits, went back to work and stopped receiving benefits, and then become disabled again, you will not have to wait five months to receive benefits, as long as no more than five years has passed between the first EOD and the second. Second, if you are applying for benefits as the child of a disabled worker, your application is not subject to any waiting period.

2. SSI Claimants

As stated previously, the established onset date for an SSI claimant cannot be earlier than the first day of the month following the date of application. This is true regardless of how long you have been disabled. In other words, you are not entitled to any back payments at the time you apply. If, however, you are appealing

the denial of your SSI claim you can start building up past-due benefits between the first day of the month following your initial application date and the date your appeal is allowed, if it is.

EXAMPLE: John has heart disease and arthritis. He applied for disability July 5, 2003. On his application, he alleges an onset date of sometime in February 2000. Review of his medical records shows that from a medical severity standpoint, he could have a medical onset date as far back as February of 2000. John is not eligible for SSDI, however—only SSI. Therefore, the SSA determines his EOD as established August 1, 2003—the first day of the month following his application date.

Appeal of Onset Date

If you are granted SSDI benefits, the SSA may establish an EOD later than you think is correct. In that situation, you can appeal the onset date by asking the DDS to do a reconsideration of the onset. Of course, there is little point in arguing about onset date if the date the SSA established covers the full 17 months before your application. Also, when you ask for an onset appeal, the entire decision may be reviewed, including the decision to grant you benefits. For more information on appealing, see Chapter 12.

Chapter 11

Reasons You May Be Denied Benefits

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When applying for Social Security disability, most people naturally think about the reasons why they should be granted benefits. You may find it useful, however, to turn the perspective around and understand the reasons why you might be denied benefits. In some cases, the reasons are beyond your control. In other instances, though, you may be able to avoid doing something that results in denial.

A. You Earn Too Much Income or Have Too Many Assets

The most basic reason to be denied benefits is that you work above the substantial gainful activity (SGA) limit when you apply. This means you earn too much money. If you are an SSDI applicant who is not blind, you are considered above the SGA if you make over \$800 per month. If you are a blind SSDI applicant, you are considered above the SGA if you make over \$1,330 per month, as of January 2003. (The limit for blind applicants adjusts each year.) Income from investments does not count toward the SGA—only work income counts. There is no such thing as partial disability based on how much money you earn. In other words, if you make \$800 per month or less as a nonblind person, you will receive the total amount of your disability check. If you make more than the \$800 SGA limit, you will receive no benefits (although there are temporary exceptions for those already receiving benefits when they attempt to return to work, as described in Chapter 13).

If you have no income other than job earnings and SSI, you could earn up to \$1189 per month in 2003 before your SSI will stop. This \$1189 maximum assumes that you have no impairment-related work expenses (IRWEs) such as a prostheses or bus fare to work. If you do, you may actually be allowed to earn more than the maximum before your SSI benefits would be cut off. How much you can earn and still receive SSI benefits also depends on the state where you live. In some states, the SSA administers a supplement to the federal SSI benefit, so that you can earn even more before your SSI cash payments stop. The best way to find out about your SSI benefits and how much you can safely earn is to contact your local

Field Office. Also, for additional information about income and resources, see Chapter 1, Section D and Chapter 13.



Once benefits begin, earning money does not always result in a termination of benefits.

For example SSDI recipients usually keep their benefits during a trial work period. Also, SSI recipients can receive special cash benefits under certain conditions in excess of the SGA levels, provided they do not exceed acceptable SSI income levels. (See Chapter 13.)

B. Your Disability Won't Last Long Enough

To qualify for SSI or SSDI benefits, the SSA must believe that your impairment is severe enough to last at least 12 months or result in your death. The only exception to this duration requirement is with blind SSI applicants. Many claims—often based on bone fractures resulting from acute trauma, such as automobile or motorcycle accidents—are denied because they are not likely to cause disability for 12 months. Almost all bone fractures heal in less than a year. If you have severe bone fractures unhealed after six months, however, the SSA is likely to think your impairment will last a year. But each case is evaluated on an individual basis.

EXAMPLE: Reg has an acute bone fracture from an automobile accident two months ago and he cannot walk. He clearly is severely impaired and unable to work. But his application for SSDI is denied because the DDS assumes that his fracture will heal in less than 12 months.

C. The SSA Cannot Find You

The SSA (including the DDS) must be able to communicate with you regarding your application. If the SSA cannot schedule examinations or communicate with you about critical matters, your benefits may be denied. If you name a representative, such as an attorney, to

handle your paperwork, you may not need to get in touch with the SSA, but be sure to stay in touch with your representative. If you move while your application is being considered, make sure the SSA knows how to contact you. Claimants get denied every day because the SSA cannot find them.

D. You Refuse to Cooperate

Your medical records may be vital to granting your disability. If you refuse to release those records to the SSA, your claim could be denied.

Similarly, the SSA may need additional information about your impairments, either because your treating doctor's medical records are incomplete or because you have no treating doctor. In these instances, the SSA will request that you be examined in something called a consultative examination (CE) with an SSA doctor, at government expense. In some cases, the SSA will require you to attend more than one CE. If you refuse to attend or request that the SSA make a determination based on the medical records already in your file, you may be denied disability because of inadequate medical information or failure to attend the CE.

If you can't make it to a scheduled CE because of the time or location, talk to your claim examiner so the DDS can schedule a CE at a time or place that is convenient for you. If you repeatedly fail to show up for a CE, however, your claim will most likely be denied. (See Chapter 5, Section C, for more on CE examinations)

E. You Fail to Follow Prescribed Therapy

If you are being treated by a doctor, but fail to follow the doctor's prescribed therapy when you have the ability to do so, you can be denied disability benefits. For the SSA to deny your claim for this reason, the therapy that you fail to follow must be one that is clearly expected to restore your ability to do economically meaningful work (known as Substantial Gainful Activity). For a child applying for SSI, the issue is whether the prescribed therapy will restore the child's

ability to function in a manner appropriate for his or her age.

If your treating doctor tells the SSA that the prescribed therapy is not likely to result in your ability to work, the SSA won't fault you if you don't follow such therapy. If your treating doctor's statement is clearly contrary to the general medical opinion, however, the SSA is not bound by it. Such opinions by your treating doctor are evaluated like other treating source opinions. (See Chapter 5, Section B.)

The SSA recognizes certain legitimate excuses for failing to follow prescribed therapy.

1. Acceptable Medical Excuses

Failure to follow prescribed therapy can be excused for reasons beyond your control. They include, but may not be limited to, the following:

- You have a mental illness so severe that you cannot comply with prescribed therapy. Severe mental disorders include mania, major depression, dementia or psychosis, such as schizophrenia.
- You have cataracts from diabetes so severe that your vision is too poor to accurately measure your insulin dose.
- You have below normal intelligence. For example, if your IQ is 70, you would not be expected to self-administer home dialysis for kidney failure. But you would be expected to swallow a pill three times a day.
- You physically cannot follow prescribed therapy without assistance—for example, because of paralysis of the arms.
- You have a fear of surgery so intense that surgery would not be appropriate. Your treating doctor must confirm the severity of your fear to the DDS consulting doctor. If your treating doctor cannot, the SSA may ask you to undergo a psychiatric examination. The SSA will not accept your refusal of prescribed surgery because success is not guaranteed or because you know someone for whom the treatment was not successful.
- The prescribed treatment is cataract surgery for one eye, and your other eye has a severe visual impairment that cannot be improved through treatment.

- The prescribed treatment is for major surgery and you've already undergone unsuccessful major surgery for this impairment.
- The prescribed treatment is very risky because of its magnitude (such as open heart surgery), unusual nature (such as an organ transplant) or another reason.
- The prescribed treatment involves amputation of an extremity or a major part of an extremity.
- A doctor who has treated you advises against the treatment prescribed by another doctor.



Parents or caregivers must follow the prescribed therapy for their children.

Young children cannot be expected to reliably administer treatments to themselves or to take pills on a regular schedule. Parents or other caregivers are responsible for children following prescribed therapy, however, or they face the risk of benefits being denied to the child.

2. Acceptable Nonmedical Excuses

It is possible that you cannot follow a prescribed therapy for a reason that has nothing to do with your medical condition. Acceptable nonmedical excuses for failing to follow prescribed therapy are described in this section.

a. Lack of Money to Pay for Treatment

The SSA will not deny you benefits for failing to follow treatment prescribed by your doctor if you don't have enough money to pay for the treatment. This frequently happens with SSI applicants who have epilepsy.

If you don't have enough money to pay for drugs or other treatments for any of your impairments, make sure the SSA knows this. Informing the SSA about your lack of money for medication is extremely important; do not assume that an examiner will know or even care about your financial plight. If the SSA can find a source of free treatment for you, then you cannot use lack of money as an excuse for not following the prescribed therapy given by your doctor.

EXAMPLE: Anna has frequent epileptic seizures because she can't afford the drugs necessary to control her seizures. Her medical records show that her epilepsy is well controlled when she takes medication. The SSA finds a free clinic in a university medical center that is willing to give her free drugs and help her obtain transportation to the clinic for treatment. In this instance, Anna cannot use lack of money as an excuse for failing to follow her doctor's prescribed treatment.

Also, if you have money and spend it on some luxury items rather than on medications, the SSA may reasonably conclude that you could afford to buy your drugs. The most common examples involve claimants who say they have no money for medications, but have money to buy cigarettes or alcohol.



Alcohol interferes with the action of anti-epileptic drugs.

Avoid alcohol if you are being treated for epilepsy. If you drink alcohol, the SSA will assume that your epilepsy would improve if you stopped drinking, or that you are failing to follow prescribed treatment recommended by your doctor. If your medical records show that you drink alcohol despite advice to the contrary from your doctor, you are likely to be denied benefits.

b. Religious Reasons

Some people's religious convictions prohibit them from receiving medical therapy. The SSA will not deny you disability for not following a prescribed therapy that is contrary to the established teaching and tenets of your religion. The SSA makes this determination by:

- identifying the church affiliation
- confirming your membership in the church, and
- documenting the church's position concerning the medical treatment by requesting relevant church literature or obtaining statements from church officials about the teachings and tenets of the church.

If you are a Christian Scientist, the SSA needs only to verify your membership in the church, because church teachings forbidding medical treatment are well established.

EXAMPLE: Dwight, a middle-aged truck driver, applied for disability benefits. He submitted a color photograph showing a huge, gaping hole several inches in diameter that looked like he had been shot through the chin and neck with a bullet. The wound was gruesome, and Dwight stated that the reason he could no longer work was that he did not want to be seen in public. He had seen a local doctor when there was only a very small skin cancer on his chin that could have easily been treated without even leaving much of a scar. However, he refused treatment because his preacher told him to pray and place his faith in Jesus to cure him. He accepted this advice, despite the progressive worsening nature of the abnormality over a period of several years. The DDS examiner evaluating the nonmedical evidence in his claim verified his church affiliation, confirmed his membership and documented through church literature and talking to the preacher that the church taught salvation through Jesus without medical care. The DDS medical consultant wanted more medical information, since Dwight's old medical records didn't establish disability and the only evidence of a severe impairment was the alleged photograph taken by his wife. With difficulty, Dwight was persuaded to go to a consultative examination paid for by the DDS, and the CE doctor on physical examination confirmed the huge, gruesome hole as a probable advanced cancer. By this time, Dwight was confined to a wheelchair and still putting his faith in Jesus. His claim was allowed.

c. Your Doctor Prescribes Incorrect Treatment

Sometimes, people receive treatment from a doctor that is not effective for their impairments. The SSA cannot interfere with the therapy given by treating doctors. If you follow your doctor's prescribed therapy, even if it is silly, you should not be faulted—that is, you should not be denied benefits. At the same time, if you refuse to follow your treating doctor's prescribed therapy and the SSA feels the treatment would not result in a significant improvement in your impairments,

the SSA should not deny your claim for failing to follow prescribed treatment. (See the end of Chapter 5 for a sidebar on how the SSA treats nontraditional therapies and how to identify bogus treatments.)

EXAMPLE 1: Sal, a young man in his 20s, applied for disability benefits on the basis of arthritis. Review of his medical records showed that he had extremely severe and rapidly progressive rheumatoid arthritis affecting most of the joints in his body. Not only did he suffer from painful inflammation around most joints, but he also had irreversible destruction of many joints. When Sal first went to a medical doctor, competent treatment could have saved his joints. But his incompetent doctor treated him only with injections of vitamin B12. Over a period of several months, Sal's faith in his doctor resulted in permanent, crippling arthritis. The SSA could not tell him that his doctor was incompetent—the SSA cannot even report such doctors to state medical authorities. Sal's disability was no fault of his own, and the SSA granted him benefits.

EXAMPLE 2: Susan has poorly controlled epilepsy of such severity that she qualifies for disability. She takes her medications as she is supposed to, but the DDS medical consultant reviewing her file can easily see that her treating doctor gives her only older types of drugs used to treat epilepsy. Newer drugs might be very effective, but apparently the treating doctor doesn't even know they exist. Susan is granted benefits.

EXAMPLE 3: Biff developed epileptic seizures following a head injury while playing football in high school. Following the advice of friends, he went to a medical doctor who said that treatment should consist of cleansing enemas, herbal teas and large doses of vitamins. The doctor said that these "natural" treatments would be effective and even sold the treatments in his office. The treatments were ineffective, uncomfortable and expensive, however, so Biff stopped doing what the doctor said. He continued to have seizures, had no money to see another doctor and so applied

for disability. He was granted the benefits—and not surprisingly, read shortly thereafter in a newspaper that the state medical board had revoked the doctor's medical license.

Keep in mind that that SSA will only consider the opinion of a medical doctor or osteopathic doctor for a physical or mental disorder. If you have a mental impairment, your treating doctor could be a licensed psychologist with a Ph.D. degree. (This doesn't matter usually, however, because a psychologist cannot prescribe drugs.)

If an alternative practitioner is treating you, you will not be denied benefits for failing to follow a prescribed therapy if that treatment is not a reasonable therapy generally recognized by the medical community.

EXAMPLE: Wilma has severe joint pains and suspects she has arthritis. She visits a doctor of naturopathy who performs a test on her called iridology, that involves analyzing the iris of her eyes. The iris is the pigmented (colored) muscle that controls the size of pupil. The naturopath suggests to Wilma that she visit her local health food store and buy certain herbs to cleanse the toxins from her body. A friend of Wilma's had been prescribed a similar treatment, which did nothing. So Wilma doesn't comply either. In this case, Wilma will not be denied benefits for failing to follow prescribed therapy.

d. You Don't Have a Treating Doctor

The SSA should never deny your claim if you do not have a treating doctor and, therefore, have no prescribed therapy for your disability, even if you have the money to see a doctor. The SSA does not define what it means to have a treating doctor. You will be considered to have a treating doctor for a particular condition if a doctor treats you in some way meant to improve your impairment and you have an ongoing treatment relationship with that doctor. You do not have to see the doctor a particular number of times, but visits should be frequent enough to reasonably believe that doctor has knowledge of your current

condition. For example, you saw a doctor several times, your medical condition stabilized with treatment and you were given a return appointment for six months later. That doctor would certainly be your treating doctor. But if you haven't seen a doctor for over six months the SSA may conclude that you no longer have a meaningful treatment relationship with that doctor.

Doctors who perform SSA consultative examinations on you are not considered treating doctors. You are not obligated to follow their treatment recommendations.

EXAMPLE: Hiro has cataracts and is blind. He applies for disability benefits. If he has the cataracts removed, he will probably be able to see fairly well. Hiro, however, doesn't have the money for such treatment. Because he could not afford to pay an eye specialist to submit a report to the DDS, he was sent to a consultative eye examination at the expense of the SSA. The examining doctor submits her report to the DDS stating that although Hiro is essentially blind, he would be able to see quite well with cataract surgery and placement of artificial lenses in his eyes. The doctor gave this recommendation to Hiro. The SSA should not deny Hiro's claim, however, because the prescribed treatment was recommended by the SSA doctor, not a treating doctor.

F. Your Disability Is Based on Drug Addiction or Alcoholism

The SSA will deny benefits to someone whose drug addiction or alcoholism (DAA) is a contributing factor to his or her disability.

The decision that DAA contributes materially to a disability is left to the SSA or DDS. In general, the medical consultant who makes the disability determination is responsible for making the DAA determination. Opinions from medical sources (including treating, nontreating and nonexamining sources), however, will be considered when making the determination. But the medical consultant will attach no special significance to the source of the opinion.

1. Is the DAA Relevant to Your Disability?

The SSA must decide if your DAA is relevant to your disability. This determination is separate from your disability determination, and is made only if all of the following are true:

- You are found to have medical impairments severe enough to be disabling.
- Medical evidence supplied by an acceptable medical source—medical doctor, osteopath or licensed psychologist—indicates that you have a DAA.
- The medical evidence is sufficient to establish the existence of a DAA—that is, it satisfies the diagnostic requirements for drug addiction or alcoholism in the *Diagnostic and Statistical Manual of Mental Disorders*. This is a book published by the American Psychiatric Association and is found in most large libraries and bookstores. It is usually just referred to as the DSM-III, DSM-IV, etc., depending on the edition. The DSM describes the diagnostic criteria needed for various mental disorders, and is an attempt to standardize the way such disorders are diagnosed. The SSA's medical criteria for disabling mental impairments is based on the DSM.



Independent corroborative evidence of your abuse is required.

The most convincing and likely information that the SSA can use is from medical records of hospitalization for drug or alcohol abuse. A statement such as “I am an alcoholic” or “I take drugs”—even recorded in your medical records by a physician or a psychologist—is insufficient evidence of drug addiction or alcoholism. Moreover, alcoholism and drug addiction implies a pattern of compulsive use. The labels do not apply to children who have physical or mental impairments resulting from their mothers’ use of alcohol or drugs during pregnancy.

2. Making a DAA Determination

The key factor a DDS medical consultant must consider when making a DAA determination is whether or not the SSA would still find you disabled if you stopped

using drugs or alcohol. The medical consultant must answer two questions:

- Which of your current physical and mental limitations would remain if you stopped using drugs or alcohol?
- Would any of these remaining limitations be disabling?

EXAMPLE: Dot drinks alcohol heavily, resulting in alcoholic inflammation of her liver (alcoholic hepatitis). Although she will eventually kill herself if she keeps drinking, the medical evidence suggests that if she stopped drinking, her condition would probably improve significantly. Despite the fact she is too drunk most of the time to work, the SSA will not find her disabled. Under the circumstances, it is reasonable for the SSA to assume she would improve if she stopped drinking.

The law does not say that permanent damage done to your body by drugs or alcohol cannot be the basis of disability. If you have some type of permanent impairment that would still be present if you stopped abusing alcohol or drugs, that impairment could be the basis of disability.

EXAMPLE 1: Billy drinks alcohol heavily, and has done so for many years. His blood clots abnormally slowly and he is physically weak. Billy’s liver is so damaged from alcoholic scarring (cirrhosis) that it is shrunken and obviously incapable of self-repair, even if he stopped drinking. In this instance, Billy’s prognosis is grim and he would be allowed benefits—although payments would be made to a representative payee who is supposed to keep Billy from spending the money on alcohol.

EXAMPLE 2: Gretchen uses large amounts of alcohol, cocaine and other drugs. She has been hospitalized for detoxification numerous times, but as soon as she hits the street she goes back to her old habits. Because she is unkempt and paranoid from drug abuse, her job prospects are grim and she is obviously unemployable. Besides, work is the farthest thing from her mind. She is exceptionally weak and barely gets around. She

has used up all the goodwill of family members and friends for money. She applies for SSI and is sent for medical evaluations. A doctor discovers that Gretchen has a heart infection known as endocarditis that resulted from her intravenous injection of drugs with dirty needles. Her heart is so damaged that it is unlikely she will survive more than few months even with treatment. Normally, Gretchen's drug abuse would prevent her from getting benefits. Her heart damage would remain if she stopped using drugs, however, and would itself be disabling. In this instance, Gretchen will be allowed benefits—again, through a representative payee.

G. You Have Been Convicted of a Crime

Certain conditions related to conviction of a crime or imprisonment will prevent you from receiving Social Security benefits. They are as follows:

- **You are in a prison after being convicted of a felony.** The one exception is if you are in a court-approved rehabilitation program that is

likely to result in your getting a job when you get released from prison and your release is within a reasonable amount of time. For example, if you won't be leaving prison for another five years, the SSA won't grant you benefits.

- **You were injured while committing a felony and were convicted of the crime.** The impairment suffered—or the worsening of an existing impairment—during the commission of a felony of which you have been convicted cannot be used as a basis for benefits.
- **You are injured while in prison.** The impairment suffered—or the worsening of an existing impairment—while you are in prison cannot be used to obtain benefits. However, in these instances, you can receive benefits after being released from prison.

H. You Commit Fraud

If you obtain disability benefits by dishonest means, the SSA can terminate your benefits and prosecute you for fraud. If you obtained benefits through fraud on the part of someone working for the SSA, your benefits can also be terminated. ■

Chapter 12

Appealing If Your Claim Is Denied

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A. Deciding Whether to Appeal

If the SSA decides that you are not eligible for benefits, that your current benefits will end or that the amount of your payments should change, you'll be sent a letter explaining the decision. If you don't agree with the decision, you can ask the SSA to reconsider. This is called an appeal. When you ask for an appeal, the SSA will look at the entire decision, even those parts that were in your favor. If you disagree with the result of the appeal, you have other options. You can appeal to an administrative law judge (see Section D3 below), the SSA Appeals Council (see Section D4 below) and, finally, to a federal district court judge (see Section D5 below). Before filing an appeal, however, you should consider your chances of winning.

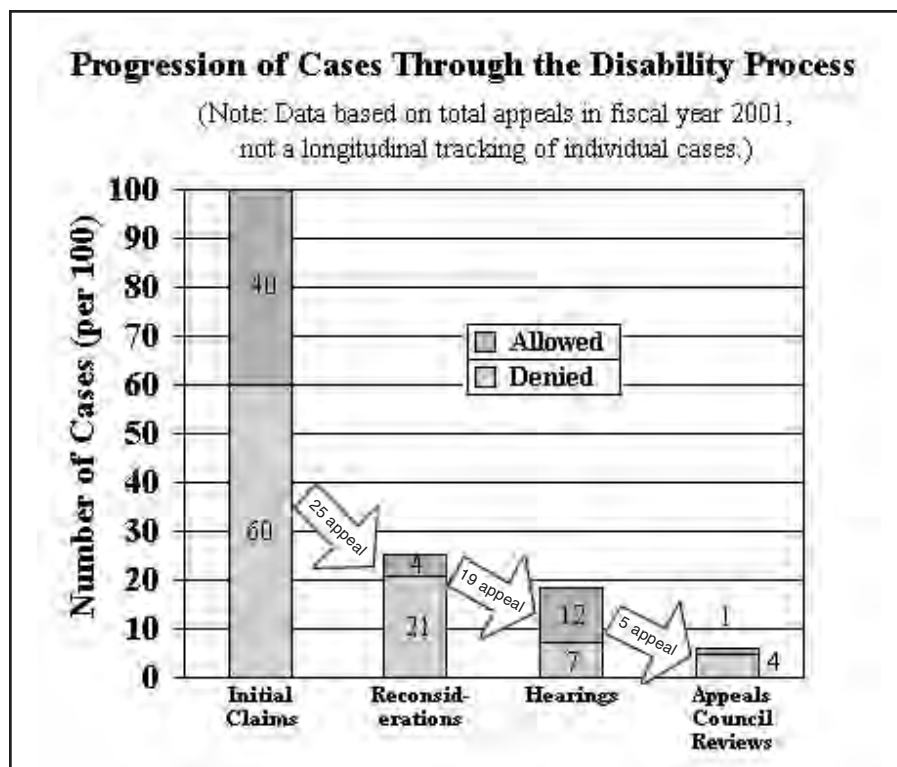


There are no costs for filing an appeal with the SSA. You can fill out the forms yourself and appear to defend your case. If you choose to hire an attorney or an authorized representative, however, you will have to pay for their services.

See the chart below for the SSA's reporting of statistics on cases granted after an appeal (from the SSA website).

Here are some issues to consider when deciding whether to appeal:

- **Is it in your best interests to appeal?** The SSA may grant you benefits after an appeal, even though you are capable of doing some sort of work. Social Security disability is only for individuals who cannot perform any kind of work, but some people can work even if they qualify. For example, there are many legally blind and totally deaf people who have rewarding jobs making many times the amount of money they could receive on disability although they would easily qualify for benefits.
- **How medically severe are your impairments?** If you have an impairment that qualifies under a listing—such as cancer—then your claim should not have been denied and you have a very good chance of prevailing during an appeal. The closer your disability fits into a listing (see Chapters 16 through 29) the greater chance you have of winning an appeal.



- **Is your impairment going to last at least a year?** Often, claimants apply for disability benefits based on bone fractures or other injuries associated with accidents. Most often these kinds of disabilities will not last a year, which is a requirement to obtain disability.
- **How old are you?** The probability of getting benefits increases with age. (See Chapters 7 and 8 for more on this issue.) If you are 55 or older, your chances are generally much better than if you are younger. However, the more severe your disability, the less your age matters.
- **What is your education?** The chance of being allowed benefits decreases the greater your education. (See Chapters 7 and 8 for more on this issue.) If you have a high school education or more, your chances of obtaining benefits radically decrease, unless your medical condition is so severe that you meet a listing (see Chapters 16 through 29) or your disability leaves you with a residual functional capacity (see Chapter 8) for less than sedentary or unskilled work. But if you have not worked for many years in a field for which you are educated, this may not be a factor.
- **What is your work experience?** The more work experience you have—especially more skilled experience—the greater the chances that the SSA will decide you can do some kind of work.
- **Can you undertake an appeal on your own or pay someone to do it for you?** Are you able to physically and mentally do the paperwork involved? Do you want to get involved in reviewing your file and commit enough of your time to the appeal process? Or are you willing to pay part of your benefits to an authorized representative who will help you?
- **Why was your claim denied?** After reviewing your SSA file, can you see incorrect statements or opinions that you can challenge? What does the file say about your impairment severity, your age, your education, your work experience? Are any of these statements in your file incorrect? Can you show that they are wrong? If you can, your chances of winning an appeal are increased.

Your decision to appeal should not be based on any one of the above factors, but on a consideration

of all of them together. If you are younger than age 55, speak English and don't qualify under a listing, then you are facing almost certain denial by a DDS. On the other hand, if you don't mind a long process of appeal to an administrative law judge, then there is a good possibility that you could be allowed even if your medical condition is not particularly severe. A few examples of cases and probable outcomes are given below.

EXAMPLE 1: Maude has been on disability for three years because of severe chest pain and weakness related to blockages of her coronary arteries. Last year, Maude had coronary artery bypass surgery. Her heart-related chest pain has disappeared and her heart tests show that she is now capable of considerably more physical activity than simply sitting. Maude's treating doctor's statements in her medical records indicate that Maude has improved significantly. Maude's physical condition appears compatible with work Maude used to do. Maude has no real reason to appeal the SSA's decision to terminate her benefits.

EXAMPLE 2: Rick is 56 years old, and has a third grade education. He has done only arduous, unskilled, heavy work his whole life. He fell from a roof doing construction work and fractured his spine. After a lengthy hospitalization, it is obvious that he cannot return to his job and he applies for Social Security disability. He has back pain if he sits or stands too long or lifts over 20 pounds. Additionally, he has difficulty bending his back. A poorly trained DDS medical consultant reviewing his initial claim ignores his symptoms, ignores his treating doctor's statement he can't lift over 20 pounds and ignores reports that he has difficulty bending. He is given an RFC for full medium work, which involves standing and walking six to eight hours daily, lifting up to 50 pounds and has no restrictions on bending. Rick has a virtual certainty of being allowed on a DDS reconsideration appeal of his claim to a different medical consultant and examiner, both because his RFC was too high, and because the examiner should have al-

lowed his claim even with a medium RFC based on his age, education and work experience.

EXAMPLE 3: Jay is 25 years old and suffered multiple bone fractures, cuts, abrasions and bruises in a motorcycle accident. He lost so much blood that right after the accident his life was in danger. Because of his injuries, he cannot return to his carpentry for about six months. He applies for Social Security disability right away and is surprised to find that the DDS denies his initial and reconsideration claims based on the fact that his fractures will be healed in less than a year. Jay's situation is like that of many claimants who apply for benefits who have serious injuries, but who are expected to recover. Until Jay can argue that his fractures are not going to heal in 12 months, his chances of being allowed benefits even on appeal are small.

EXAMPLE 4: Jay's brother Jim, age 27, was also injured in the motorcycle accident, but he was not wearing a helmet and suffered a serious head injury. He had a fractured skull with bone fragments pushed into his brain. He was in the hospital for a month after brain surgery, before he was finally allowed to go home to the care of his wife, Lorraine. He has severe difficulty with memory and thinking, characteristic of organic brain syndrome. With intense rehabilitation he has been slowly improving. Before he left the hospital Lorraine filed for disability benefits on his behalf, but Jim's claim was denied. The denial notice indicated that, although Jim's brain injury was disabling at the present time, it was expected that he would recover in less than 12 months.

As Jim's guardian, she decided to review Jim's file and found that the DDS medical consultant had predicted that, based on Jim's slow improvement with rehabilitation, he would be capable of at least unskilled work within 12 months after his injury. Lorraine discovered two serious problems with Jim's denial. First, the DDS medical consultant was a neurologist rather than a psychiatrist, and should not have been evaluating Jim's mental condition. She knew that the consultant was a neurologist, because of the specialty code entered on the Form SSA-831-C3/U3: Disability Determina-

tion and Transmittal (see sidebar in Section D1c below for the codes). Second, based on the discussion of cerebral trauma Listing 11.18 in Chapter 26, she knew that SSA policy requires that cases of traumatic brain injury at allowance level severity never be denied on the presumption they will improve to a denial level of severity in 12 months.

Lorraine arranged for Jim to appeal for reconsideration at the DDS, pointing out both in writing and telephone calls to the agency director that Listing 11.18 cross refers organic brain syndrome evaluation to Listing 12.02, the adult mental listing specifically dealing with organic brain syndrome. Lorraine informed the director that she knows that evaluation of mental disorders must be done by a psychiatrist or psychologist, and also that the consultant should not have guessed that Jim's condition would improve. The DDS director was embarrassed and assured Lorraine that on reconsideration Jim's claim would be assigned to a medical consultant who would properly evaluate it. Within a week, Jim's claim for benefits was allowed, after being reviewed by a DDS psychiatrist who properly applied the law.

Appeal Myths Versus Reality

Beware of myths about the way the SSA and DDS agencies operate. One prevalent myth is that the SSA denies every initial application as a matter of policy. Not true. It would require a conspiracy of every DDS medical consultant, DDS director, DDS examiner and federal reviewers of DDS work to disregard federal laws and regulations. The truth is that about 40% of initial claims are granted and 5% of reconsideration claims.

Lawyers tell some claimants that the initial decision doesn't matter—that going before an administrative law judge after a denial is what's important. But if you are denied benefits by the DDS and have to appeal, your case could be delayed a year or more. So from your point of view, what happens at the DDS level does matter. Your chances of prevailing are better before an ALJ. Typical ALJs allow about two-thirds of claims they hear and some allow 99%.

1. Forms, Notices and Rationales

The SSA uses hundreds of specialized forms and notices to communicate with claimants and recipients. It is not possible to include every disability form and notice in this book—or even to list them. Also, the SSA regularly makes changes in administrative procedures that affect the use of forms, notices and rationales.

a. Forms

Forms are the way the SSA obtains basic information, such as claimant names and addresses, and dates and types of claims. The SSA also uses forms to communicate its activities, such as disability determinations, or to transmit important information between the DDS and the SSA. Many forms are designed to be completed by claimants. At the same time, you will never see some forms unless you review your file during an appeal.

b. Notices

Notices are SSA form letters used to communicate with claimants. The SSA must send a written notice to you notifying you of any determination or decision about your entitlement to benefits or planned action that will adversely affect your current or future entitlement to benefits.

For example, notices may tell you whether your claim is denied or allowed, or whether your claim is going to undergo a continuing disability review. Most notice forms have some type of identifier that begins with the letter L, such as SSA-L1675-U2: Notice of Reconsideration.

In addition to regular notices, the SSA sometimes sends out advance predetermination notices to SSDI claimants. These advance notices:

- inform you of action the SSA plans to take—such as a termination of benefits because you are performing Substantial Gainful Activity
- summarize the evidence in your file which supports the proposed determination
- advise you how to present evidence that may change the planned action, and
- tell you how long you have to respond to the notice.

c. Rationales

Rationales are explanations of SSA determinations and are sent on Form SSA-4268. The form contains your name, Social Security number and type of claim, and then a rationale—either a personalized explanation or a technical explanation.

The purposes of the disability determination/hearing decision rationales are to:

- identify the medical and nonmedical factors that have been considered
- explain the process the SSA used to arrive at the determination, and
- provide a permanent record of evidence of the reasons underlying the conclusion.

Rationales are extremely important when your claim is denied. Mistakes contained in SSA rationales can help you understand what went wrong and provide the basis for an appeal.

i. Personalized Explanation Rationales

If you receive an unfavorable decision notice—such as denying your application or ending your benefits—it will include a personalized explanation. You may also receive an attachment with the notice, detailing additional reasons for your denial.

Personalized explanations are written to be understood by someone with at least a sixth grade education. They avoid abbreviations, jargon, technical terms, complex medical phrases or personal statements about you that have nothing to do with your actual disability determination. Although the SSA uses some stock sentences in personalized explanations, your specific personal disability determination must be explained.

The personalized explanation must contain the following elements:

All medical and nonmedical sources used in evaluating your claim. Nonmedical sources (such as school guidance counselors, welfare departments, vocational rehabilitation agencies, day treatment facilities, sheltered workshops, social workers and family members) are listed as evidence sources but not identified by name.

An explanation for the denial. The explanation depends on the type of claim you have. In the denial of an initial claim the SSA might say: “We have determined that your condition is not severe enough

to keep you from working. We considered the medical and other information, your age, education, training and work experience in determining how your condition affects your ability to work.”

A list of the impairments evaluated. If you have a mental impairment or are unaware of the exact nature of your condition, the rationale may be worded in such a way as to not offend or upset you. For example, if you are unaware of an impairment, the SSA will say something general such as “The evidence does not show any other conditions which significantly limit your ability to work.”

A brief description of your medical condition. Read this carefully to see if you agree with the description and that nothing has been left out.

If the denial is because the SSA believes you can do your prior work, the letter will include the job the SSA thinks you can return to. The SSA does not have to include information about your residual functional capacity (see Chapter 8) if the job is consistent with your description of your past work. If the physical or mental work you did and described to the SSA differed from what is generally required for the job, the SSA will advise you that you can return to the job as it is generally performed.

Note that the following three examples have had doctor and hospital names and dates removed that must be listed in actual notice rationales. If the DDS fails to list some of your important medical sources, you can assume that they were not used in your disability determination. This can be the basis for an appeal. These examples of personalized explanations are the type that might be included with the initial claim denial notice in Section D1.



Form SSA-4268, Example 1

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training and work experience in determining how your condition affects your ability to work. You said that you are unable to work because of a back condition. The medical evidence shows that you were operated on for a slipped disc. There are no signs of severe muscle weakness or nerve damage. While you cannot do heavy work, you are now able to do light work not requiring frequent bending. Based on your description of the job of rug inspector that you performed for the past 15 years, we have concluded that you can return to this job. If your condition gets worse and keeps you from working, write, call or visit any Social Security office about filing another application.

If the denial is because the SSA believes you can do work other than your prior work, a statement will be included saying you have the ability to do work that is less demanding. The SSA will generally refer to your physical and mental abilities, and skill level, and will state that you can do a job that requires less physical effort than your previous work. The SSA will say this in general terms, rather than refer to specific jobs. For example, it might say: “you can do lighter work.”

Form SSA-4268, Example 2

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training and work experience in determining how your condition affects your ability to work. You said that you are unable to work because of pain and stiffness in your knees and lower back. The medical evidence shows that you have arthritis in your knees and back which causes you discomfort. We realize that your condition prevents you from doing any of your past jobs, but it does not prevent you from doing other jobs which require less physical effort. Based on your age (52), education (9th grade) and past work experience, you can do other work. If your condition gets worse and keeps you from working, write, call or visit any Social Security office about filing another application.

Form SSA-4268, Example 3

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training and work experience in determining how your condition affects your ability to work. You said that you were unable to work because of “nerves.” The medical evidence shows that you have anxieties that make it difficult to return to your prior work as a traveling saleswoman. You also complained that you have arthritis in your hands and back. We realize that your conditions prevent your return to any type of work requiring frequent interaction with the public, or from being able to do heavy lifting. However, your condition does not prevent you from performing other types of jobs requiring less mental stress or in performing light lifting. Based on your age (45), education (high school graduate) and past work experience, you can do other work. If your condition gets worse and keeps you from working, write, call or visit any Social Security office about filing another application.

If the denial is because the SSA believes your condition won’t last 12 months or result in your death, the rationale must address this issue.

Continuing Disability Review Rationales

In personalized explanations for continuing disability review (CDR) claims, the rationale will also include the dates and reasons you were granted disability in the prior decision and why you are no longer considered disabled—for example, you have had medical improvement, you have started working or there was an error in the prior determination. CDR claims are covered in Chapter 14.

If the SSA does not include the above elements, it has been deficient in its explanation and possibly in the determination of your claim and you should consider appealing.

ii. Technical Rationales

Technical rationales are more detailed than personalized explanations, are medically complex and may refer to specialized references, such as the *Dictionary of Occupational Titles*, and specific medical-vocational rules. The SSA does not send you the technical rationale, but it is a part of every file and can give deep insight into why a claim was denied.

We have included a number of real technical rationales in Appendix B. It is useful to review them when considering whether to file an appeal of a denial of benefits.

Personalized denial notices you received in the mail won’t be in your DDS file, but the technical rationales and official determination forms will be. Your DDS only retains your file for about six months. After that, it is sent to a storage facility. You should ask your local SSA Field Office for help locating the file and getting you a copy.

B. Appeal Basics

Enclosed with the notice from the SSA denying or terminating your benefits will be information on how to appeal the decision. You must appeal in writing within 60 days of the date that you receive the notice. The SSA assumes that you received the letter five days after the date on the letter, unless you can show you received it later. If you fail to appeal within 60 days, you probably lose your right to appeal—the SSA rarely makes exceptions. Of course, if you have a problem like an unexpected hospitalization the SSA might be willing to overlook a late appeal.



If you miss the appeal deadline. You can always start over again with a new initial claim, have it denied and then appeal. Given the time involved, however, try to avoid starting over.

Starting the appeal process is not difficult. You simply call your local Social Security Field Office and state that you want to appeal a decision to deny you or terminate your benefits. They will send you the proper forms and tell you where to mail them when they are completed. The different levels of appeal are each discussed in detail in Section D below.

If you are nearing the 60-day deadline for filing the appeal forms, write a letter stating that you will be appealing and asking for the forms. If you live near a Field Office, the easiest way to speed things along might be to go in person to complete the forms and ask any questions you might have of the Social Security representative. Remember, however, that even if you are completing the forms in your home, you can still call the Field Office for help completing them.

- To appeal from a denial of initial benefits, you must file Forms SSA-561-U2, SSA-3441-F6 and SSA-827. This starts your first level of appeal for reconsideration. These forms are discussed in more detail in Section D1a below, and are filed at your local Social Security Field Office.
- To appeal from an initial termination of benefits, you must file Forms SSA 789-U4 and SSA-782-BK. This starts your first level of appeal for reconsideration. These forms are discussed in more detail in Section D2a below, and are filed at your local Social Security Field Office.
- To appeal from a denial by the SSA of a reconsideration claim, you must file Forms HA-501-U5, HA-4486 and SSA-827. This starts your appeal to an administrative law judge (ALJ). These forms are discussed in more detail in Section D3a below, and are filed at your local Social Security Field Office.
- To appeal from denial of a claim before an ALJ, you must file Form HA-520-U5. This starts your appeal to the Appeals Council. This form is discussed in more detail in Section D4a, and is mailed directly to the Appeals Council.
- To appeal from denial by the Appeals Council, you can sue the SSA in federal district court, as discussed in more detail in Section D5.

It is possible to have your claim reopened and evaluated again without actually appealing. Reopenings are explained in Section E. Also, if you lose all of your appeals, you can file another initial claim and start all over again as discussed in Section F.

1. How Long Appeal Decisions Take

The first level of appeal—reconsideration of an initial denial by a DDS—is the quickest, because your file is

likely still at the DDS and it is simply reviewed by a different medical consultant and examiner from the pair that made the original decision. If the DDS does not have to wait for additional medical records and the agency's caseload is not too high, you might get a decision in a few weeks to a month. However, the review could take four months or longer in a DDS with a heavy caseload.

Similarly, if a disability hearing officer is reviewing a decision to terminate benefits it might be completed in less than a month if the DHO doesn't have a large backlog of claims for hearings and all of the records you want reviewed are already in your file. But it is more likely you will have to wait several months.

Once you get to the next level of appeal before an administrative law judge, decisions really slow down—you could easily wait for a year or longer for a hearing. On further appeal to the Appeals Council, you'd probably be lucky to get any kind of answer within a year.

Appeals to a federal court typically take about a year for a decision—but several years is also quite possible. Federal court judges are not special judges who decide only disability claims; they have many kinds of cases on their schedule that have nothing to do with Social Security disability, so your claim will have to wait its turn.



More information on appeals. If you have questions about your right to appeal, call the SSA at 800-772-1213 or call your local SSA Field Office. All calls to the SSA are confidential. You can also find a considerable amount of information about appeals, including many forms and informational booklets, on SSA's website at www.ssa.gov.

2. Receiving Benefits While Appealing

If you are receiving benefits and the SSA decides to terminate you after a continuing disability review (see Chapter 14), you may continue receiving your benefits while you appeal (42 U.S.C. §1631(a)(7)) if the SSA decided:

- you are no longer eligible for SSDI because your condition has improved, or
- you are no longer eligible for SSI or that your SSI will be reduced.

If you want your benefits to continue, you must tell the SSA within ten days of when you receive the denial notice, by signing and returning Form SSA-795, which should be provided by the local SSA Field Office with the termination notice.

C. Your Right to Representation

Some people handle their own Social Security appeal. But you can appoint a lawyer, a friend or someone else, called your *authorized representative*, to help you. The SSA will work with your representative just as it would work with you. At the first level of appeal—reconsideration by the DDS—many claimants do not have representation. But this changes as the appeals move further along; 80% of claimants use a representative when they appeal to an administrative law judge.

Your representative can act for you in most Social Security matters and will receive a copy of all SSA correspondence. Your representative cannot charge or collect a fee from you without first getting written approval from the SSA. (For more information on using a representative, see Chapter 15.)

D. Four Levels of Appeal

There are four levels of appeal of an SSA decision, and you cannot skip any steps in the process. The appeal levels are:

- reconsideration of claim
- hearing by an administrative law judge
- review by the appeals council, and
- review by a federal court.

Each is discussed below. The request for reconsideration is discussed twice—once for original claims and once for terminations or reductions following a continuing disability review.

1. Request for Reconsideration of Original Claim

If your application for benefits is denied, you will receive a notice to that effect. The exact language of

the notice depends on whether your claim is for SSDI, SSI, a combination of both or subcategories such as auxiliary benefits (see Chapter 1). The denial notice example below is for an initial SSDI claim, but shows the kind of language you can expect in any denial of an initial claim.

In addition to telling you that you are not entitled to benefits, the notice may explain other basic information about Social Security disability claims (not included here), as well as your right to appeal. A personalized explanation paragraph about your medical condition either will be merged into the text of the notice or be on a separate attachment.

Contact your local Field Office for help initiating your reconsideration appeal. Do not contact the DDS directly, as they do not accept appeal applications. The Field Office will send the DDS your prior file and the DDS will then contact you as was done on your initial claim. Once a DDS reconsideration examiner has your file, you will communicate with the DDS officer. Of course, you can still call the Field Office and ask any general questions about appeals that you want, but issues regarding the disability determination decision rests with the DDS. The notice on the following page is the kind you might expect to see if your initial DDS claim were denied.

a. Complete the Forms

The forms you need to request a reconsideration are:

- Form SSA-561-U2: Request for Reconsideration
- Form SSA-3441-F6: Reconsideration Disability Report, and
- Form SSA-827: Authorization for Source to Release Information to the SSA.



You must use forms provided by the SSA. You can obtain them at your local SSA Field Office or by calling the SSA hotline at 800-772-1213, Monday through Friday (except holidays), from 7 a.m. to 7 p.m. If you are deaf or hard of hearing, TTY service representatives are available at the same times at 800-325-0778. You can also download many necessary forms from the Social Security Administration website at www.ssa.gov. These forms are not available from the DDS. Each form comes with its own instructions. Also, if you ask, the SSA will assist you in completing them.

Letter From Social Security Administration Denying Initial DDS Claim**Social Security Notice**

From:
Social Security Administration

Date:
Claim Number:

- ☐ Disability Insurance Benefit
- ☐ Disabled Widow/Widower Benefits
- ☐ Childhood Disability Benefit

We have determined that you are not entitled to disability benefits based on the claim that you filed. The attached page explains why we decided that you are not disabled. However, you may appeal this determination if you still think you are disabled.

The determination on your claim was made by an agency of the State. It was not made by your own doctor or by other people or agencies writing reports about you. However, any evidence they gave us was used in making this determination. Doctors and other people in the State agency who are trained in disability evaluation reviewed the evidence and made the determination based on Social Security law and regulations. The law is explained on the back of this page.

In addition, you are not entitled to any other benefits based on this application. If you applied for other benefits, you will receive a separate notice when a decision is made on that claim (s).

YOUR RIGHT TO APPEAL

If you think we are wrong, you can ask that the determination be looked at by a different person. This is called a reconsideration. IF YOU WANT A RECONSIDERATION, YOU MUST ASK FOR IT WITHIN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. IF YOU WAIT MORE THAN 60 DAYS, YOU MUST GIVE US A GOOD REASON FOR THE DELAY. Your request must be made in writing through any Social Security office. Be sure to tell us your name, Social Security number and why you think we are wrong. If you cannot write to us, call a Social Security office or come in and someone will help you. You can give us more facts to add to your file. However, if you do not have the evidence yet, you should not wait for it before asking for a reconsideration. You may send the evidence in later. We will then decide your case again. You will not meet with the person who will decide your case. Please read the enclosed leaflet for a full explanation of your right to appeal.

NEW APPLICATION

You have the right to file a new application at any time, but filing a new application is not the same as appealing this decision. You might lose benefits if you file a new application instead of filing an appeal. Therefore, if you think this decision is wrong, you should ask for an appeal within 60 days.

Enclosure:
SSA Publication No. 05-10058
Form SSA-L443-U2 (2-90)

Form SSA-561-U2: Request for Reconsideration, Page 1

SOCIAL SECURITY ADMINISTRATION		TOE 710	
REQUEST FOR RECONSIDERATION			(Do not write in this space)
The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 - 416.1421). While your responses to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.			
NAME OF CLAIMANT		NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from claimant.)	
1 Myrtle Johnson		2	
SOCIAL SECURITY CLAIM NUMBER		SUPPLEMENTAL SECURITY INCOME (SSI) CLAIM NUMBER	
3 987-65-4321		4 A4307310	
SPOUSE'S NAME (Complete ONLY in SSI cases)		SPOUSE'S SOCIAL SECURITY NUMBER (Complete ONLY in SSI cases)	
5		6	
CLAIM FOR (Specify type, e.g., retirement, disability, hospital insurance, SSI, etc.)			
7 disability			
I do not agree with the determination made on the above claim and request reconsideration. My reasons are:			
8 The reviewer did not consider my doctor's statement that I met the listing and my illness is degenerative			
SUPPLEMENTAL SECURITY INCOME RECONSIDERATION ONLY (See reverse of claimant's copy)			
"I want to appeal your decision about my claim for supplemental security income, SSI. I've read the back of this form about the three ways to appeal. I've checked the box below."			
9 ☒ Case Review ☐ Informal Conference ☐ Formal Conference			
EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH			
SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE		CLAIMANT SIGNATURE	
☐ NON-ATTORNEY ☐ ATTORNEY		10 Myrtle Johnson	
STREET ADDRESS		STREET ADDRESS	
CITY		CITY	
STATE		STATE	
ZIP CODE		ZIP CODE	
TELEPHONE NUMBER (Include area code)		TELEPHONE NUMBER (Include area code)	
DATE		DATE	
11 555-555-5555		1/27/02	
TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION			
See reverse of claim folder copy for list of initial determinations			
1. HAS INITIAL DETERMINATION BEEN MADE? ☐ YES ☐ NO		2. CLAIMANT INSISTS ON FILING ☐ YES ☐ NO	
3. IS THIS REQUEST FILED TIMELY? (If "NO", attach claimant's explanation for delay and attach only pertinent letter, material, or information in social security office.) ☐ YES ☐ NO			
RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)			SOCIAL SECURITY OFFICE ADDRESS
☐ NO FURTHER DEVELOPMENT REQUIRED (GN 03102.125)			
☐ REQUIRED DEVELOPMENT ATTACHED			
☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS			
ROUTING INSTRUCTIONS (CHECK ONE) →	☐ DISABILITY DETERMINATION SERVICES/ROUTE WITH DISABILITY FOLDER	☐ ODO, BALTIMORE	☐ PROGRAM SERVICE CENTER
	☐ INTPSC, BALTIMORE	☐ DISTRICT OFFICE RECONSIDERATION	☐ OCRO BALTIMORE
NOTE: TAKE OR MAIL COMPLETED COPIES TO YOUR SOCIAL SECURITY OFFICE			
Form SSA-561-U2 (9-85) EF (8-99)		CLAIMS FOLDER	

i. Form SSA-561-U2: Request for Reconsideration

This form is to be used for the first request for reconsideration of the denial of an initial claim. If you are uncertain whether this is the appropriate request to file, look at the letter you received from the SSA. Use this form if the letter says you have a right to file a request for reconsideration. If you have further questions, call 800-772-1213 or contact your local SSA office.

Here are instructions on how to fill out the form. A completed sample follows.

1 Name of Claimant: Enter your name or the name of the person on whose behalf this reconsideration is being filed.

2 Name of Wage Earner or Self-Employed Individual: Enter your name or the name of the person on whose record you applied for Social Security benefits.

3 Social Security Claim Number: Enter the Social Security number of the wage earner identified in number 2 with the appropriate suffix—such as HA, B2, C1 or D, which can be located on all correspondence you receive from SSA.

4 Supplemental Security Income (SSI) Claim Number: For SSI Claimants. If an application for SSI was rejected, enter the claimant's Social Security number.

5 Spouse's Name: Enter only if you applied for SSI.

6 Spouse's Social Security Number: Enter only if you applied for SSI.

7 Claim For: Enter SSI Disability or Social Security Disability.

8 "I Do Not Agree ... My Reasons Are:" Briefly state the decision with which you disagree and why you disagree with the decision—use the back of the form or a continuation sheet if you need more room. For example, "I don't agree that I can lift 50 pounds and stand 6–8 hours daily. I intend to submit more medical information as well as my treating doctor's opinion about my limitations."

9 The Form SSA-561-U2 attachment explains the different ways to handle an SSI appeal. Read it and mark your preference here.

10 On the right side, sign the form and enter your address. If a legal representative is handling your

appeal (see Chapter 15), that person must sign on the left side and enter an address, and must complete and return Form SSA-1696. The SSA cannot discuss your case with your legal representative until it receives Form SSA-1696.

11 Provide your daytime phone number.

ii. Form SSA-3441-F6: Reconsideration Disability Report

Use this form to update your disability information when requesting a reconsideration of your initial claim. Here are instructions on how to fill it out. A completed sample follows.

1 Date Claim Filed: Fill in the date you filed your application for disability benefits. This date is on the receipt you were given when you filed the claim.

2 Part I: Here you describe changes in your medical condition since the interview you had when you filed your application. Answer the questions as thoroughly as possible. Mention all changes in your impairments, symptoms, limitations, daily needs and daily activities. If you've experienced no changes in any of these, state that in question 2.

3 Part II: Here you provide the name, address and phone number of all medical sources you have contacted since the date you filed your application. Include doctors, hospitals, clinics, laboratories and other sources of medical information. List all the information for each source, even if the source was included on your original disability application. Note the treatments received and the dates and reasons for the treatments.

4 Part III: Here you provide information about any work you have done since you filed your initial disability claim. If this applies to you, contact your local Social Security office or call 800-772-1213 for information regarding how working may affect your reconsideration process.

5 Part IV: Describe what assistance you may need in caring for yourself. Be as specific as possible. If your activities have changed since you filed your claim, describe the changes and what prompted them.

6 Part V: Read the authorization and enter a phone number where you can be reached.

Form SSA-3441-F6: Reconsideration Disability Report, Page 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

Form Approved
OMB No. 0960-0144

For SSA Use Only - Do NOT Complete This Item.	
Name of Wage Earner <i>John Samuels</i>	Social Security Number <i>666-66-6666</i>
Name of Claimant <i>Same</i>	Social Security Number
Type of Claim:	
Title II - ☐ Freeze ☒ DIB ☐ DWB ☐ CDB Title XVI - ☒ Disability ☐ Blind ☐ Child	

RECONSIDERATION DISABILITY REPORT

PLEASE PRINT, TYPE OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, answer all questions. COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.

PRIVACY ACT/PAPERWORK REDUCTION ACT NOTICE: The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1633(a) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your claim and could result in the loss of benefits. Although the information you furnish on this form is almost never used for any purpose other than making a determination on your disability claim, such information may be disclosed by the Social Security Administration as follows: (1) To enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., the General Accounting Office and the Veterans Administration); (3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security). These and other reasons why information about you may be used or given out are explained in the **Federal Register**. If you would like more information about this, any Social Security office can assist you.

Date Claim Filed **1** 12-12-2003

PART I - INFORMATION ABOUT YOUR CONDITION

1. Has there been any change (for better or worse) in your illness or injury since you filed your claim? ☒ Yes ☐ No
If "Yes," describe any changes in your symptoms.

High blood pressure and chest pain worse. Arthritis in hands hurts more. I'm more depressed.

2. Describe any physical or mental limitations you have as a result of your condition since you filed your claim.

Can't lift as much without chest pain, or pain in my hands. I'm depressed and not interested in doing much.

3. Have any restrictions been placed on you by a physician since you filed your claim? ☒ Yes ☐ No
If "Yes," give name, address, and telephone number of the physician and show what kinds of restrictions have been imposed.

Dr. Morris said I shouldn't lift more than 20 lbs., and that I should not work in the cold. Also, that I should avoid stress. 1200 Lakepark Rd., Little Rock, AR 72201, 501-555-1212

4. Do you have any additional illness or injury that you feel we should know about? ☒ Yes ☐ No
If "Yes," describe the kind of illness or injury and the date that it occurred.

I'm more dizzy since Dr. Morris increased my heart drugs on January 2, 2003.

Form SSA-3441-F6: Reconsideration Disability Report, Page 2

3

PART II - INFORMATION ABOUT YOUR MEDICAL RECORDS

5. Have you seen any physician since you filed your claim? ☒ Yes ☐ No
If "Yes," provide the following about the physician you last visited:

NAME Dr. David Morris	ADDRESS (Include ZIP Code) 1200 Lakepark Road Little Rock, AR 72201
AREA CODE AND TELEPHONE NUMBER 501-555-5555	
HOW OFTEN DO YOU SEE THIS PHYSICIAN? once a month	DATE YOU SAW THIS PHYSICIAN 12-2-2003

REASONS FOR VISITS

High blood pressure. Chest pain (angina)

TYPE OF TREATMENT RECEIVED (Include drugs, surgery, tests)

Drugs. Exercise test for heart. Nitroglycerine for chest pain

6. Have you seen any other physician since you filed your claim?..... ☒ Yes ☐ No
If "Yes," show the following:

NAME Dr. Beverly Jones	ADDRESS (Include ZIP Code) 371 Lyle Avenue North Little Rock, AR 72214
AREA CODE AND TELEPHONE NUMBER 501-555-6666	
HOW OFTEN DO YOU SEE THIS PHYSICIAN? every 3 months	DATE YOU SAW THIS PHYSICIAN 12-5-2003

REASONS FOR VISITS

arthritis in my hands.

TYPE OF TREATMENT RECEIVED (Include drugs, surgery, tests)

Drugs—ibuprofen for pain in hands

If you have seen other physicians since you filed your claim, list their names, addresses, dates and reasons for visits in Part V.

7. Have you been hospitalized, or treated at a clinic or confined in a nursing home or extended care facility for your illness or injury since you filed your claim?..... ☐ Yes ☒ No
If "Yes," show the following:

NAME OF FACILITY	ADDRESS OF AGENCY (Include ZIP Code)
PATIENT OR CLINIC NUMBER	
WERE YOU AN INPATIENT? (Stayed at least overnight) ☐ Yes ☐ No IF "YES," SHOW →	DATES OF ADMISSIONS AND DISCHARGES
WERE YOU AN OUTPATIENT? ☐ Yes ☐ No IF "YES," SHOW →	DATES OF VISITS
REASON FOR HOSPITALIZATION, CLINIC VISITS, OR CONFINEMENT	

TYPE OF TREATMENT RECEIVED (Include drugs, surgery, tests)

If you have been in other hospitals, clinics, nursing homes, or extended care facilities for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization, clinic visits, or confinement in Part V.

8. Have you been seen by other agencies for your injury or illness?..... ☐ Yes ☒ No
(VA, Workmen's Compensation, Vocational Rehabilitation, Welfare, Special Schools, Unions, etc.)
If "Yes," show the following:

NAME OF AGENCY	ADDRESS OF AGENCY (Include ZIP Code)
YOUR CLAIM NUMBER	
DATES OF VISITS	NAME OF COUNSELOR, SOCIAL WORKER, ETC.

TYPE OF TREATMENT OR EXAMINATION RECEIVED (Include drugs, surgery, tests)

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part V.

Form SSA-3441-F6: Reconsideration Disability Report, Page 3

4

PART III - INFORMATION ABOUT WORK

9. Have you worked since you filed your claim?..... ☒ Yes ☐ No

If "Yes," you will be asked to give details on a separate form.

5

PART IV - INFORMATION ABOUT YOUR ACTIVITIES

10. How does your illness or injury affect your ability to care for your personal needs?

I can take care of most of my personal needs, but I do have trouble with the buttons on my shirt.

11. What changes have occurred in your daily activities since you filed your claim?

(If none, show, "None")

I can no longer work in my shop, in my garden, or do yard work. I can't play the piano any more. I don't want to be around other people any more; I'd rather stay to myself.

6

PART V - REMARKS AND AUTHORIZATIONS

- 12.(a) READ CAREFULLY: I authorize the Social Security Administration to release information from my records, as necessary to process my claim, as follows:

Copies of my medical records may be furnished to a physician or a medical institution for background information if it is necessary for me to have a medical examination by that physician or medical institution. The results of any such examination may be given to my personal physician.

Information from my records may also be furnished, if necessary, to any company providing clerical and administrative services for the purposes of transcribing, typing, copying or otherwise clerically servicing such information. The State Vocational Rehabilitation Agency may also have access to information in my records to determine my eligibility for rehabilitative services.

I understand and concur with the statement and authorizations given above, except as follows (If there are no exceptions, write "None" in the space below. If you do not concur with any part of the above statement, state your objections clearly):

12.(b)	Telephone number where you can be reached:	Best time to reach you:
	<i>501-777-7777</i>	<i>8 a.m. to 9 a.m.</i>

Form SSA-3441-F6: Reconsideration Disability Report, Page 4

- 7 12.(b) Use this section to continue information required by prior sections. Identify the section for which the information is provided. Note: This section may also be used for any special or additional information which you wish to be recorded.

Some of the drugs my doctors give me make me feel weaker. I've been losing weight, because I don't feel like eating much. Nothing seems to interest me much any more, and Dr. Morris says I should see a psychiatrist for my depression. But I can't afford that.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

These and other reasons why information about you may be used or given out are explained in the *Federal Register*. If you want to learn more about this, contact any Social Security office.

TIME IT TAKES TO COMPLETE THIS FORM

We estimate that it will take you about 30 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, or on any other aspect of this form, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001, and to the Office of Management and Budget, Paperwork Reduction Project (0960-0144), Washington, D.C. 20503. **Send only comments relating to our estimate or other aspects of this form to the offices listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office, whose address is listed in your telephone directory under the Department of Health and Human Services.**

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law, I certify that the above statements

NAME (SIGNATURE OF CLAIMANT OR PERSON FILING ON THE CLAIMANT'S BEHALF)

SIGN
HERE



John Samuels

DATE

12-11-2003

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of Witness

2. Signature of Witness

Address (Number and street, city, state, and ZIP code)

Address (Number and street, city, state, and ZIP code)

Form SSA-3441-F6: Reconsideration Disability Report, Page 5

PART VI - FOR SSA USE ONLY - DO NOT WRITE BELOW THIS LINE

Name of Wage Earner <i>John Samuels</i>	Social Security Number <i>456-78-9012</i>
Name of Claimant <i>same</i>	Social Security Number

13. Check each item to indicate whether or not any difficulty was observed:
(Explain all items checked "Yes," in Item 14 below)

Reading:	☐ Yes	☒ No	Using Hands:	☒ Yes	☐ No
Writing:	☒ Yes	☐ No	Breathing:	☐ Yes	☒ No
Answering:	☐ Yes	☒ No	Seeing:	☐ Yes	☒ No
Hearing:	☐ Yes	☒ No	Walking:	☐ Yes	☒ No
Speaking:	☐ Yes	☒ No	Sitting:	☐ Yes	☒ No
Understanding:	☐ Yes	☒ No	Assistive Devices:	☐ Yes	☒ No
Other (Specify):					

14. If any of the above items were checked "Yes," describe the observed difficulty:

Mr. Samuels' hands seemed to have enlarged joints, and his fingers looked deformed. He had difficulty holding a pen and writing.

15. Describe fully: General appearance, behavior, any unusual observed difficulties not noted elsewhere, any unusual circumstances surrounding the interviews.

Seemed withdrawn, depressed. Appeared sad. Said he felt life was hopeless because he couldn't work and provide for his family. Said he had trouble sleeping. Needed a shave, otherwise neat and clean in casual clothes.

Form SSA-3441-F6: Reconsideration Disability Report, Page 6

16. Claimant requires assistance ☐ Yes ☒ No

If "Yes," show name, address, phone number, and relationship of interested person.

Also show why claimant requires assistance (foreign-speaking, unable to ambulate, etc.)

17. Capability development appears needed ☐ Yes ☒ No

If "Yes," indicate whether DO will undertake development because it is also developing medical evidence from a special arrangement source. (Show name and address of source.)

18. Is development of work activity necessary? ☐ Yes ☒ No

If "Yes," is an SSA-821 or SSA-820-F4 ☐ Pending ☐ In File

19. SSA-3441 Taken By:

☒ Personal Interview

☒ DO/BO ☐ Home ☐ Other _____

☐ Telephone

☐ Mail

Signature of Interviewer or Reviewer

Joe Daniels

Title

Claims Representative

DO, BO, or TSC

DO/FO

Date

12-11-03

7 12(b). Use this space to continue your answer to any questions, making sure you note the question number to which you are referring. You can also use this section to add any other information you want considered. For example, if, in your initial claim, the DDS didn't consider a certain impairment or relied on incorrect information provided by your treating physician, state that.

If you run out of room, attach a blank sheet of paper as a continuation sheet—at the top write your name, Social Security number and SSA-3441-F6-CONT.

iii. Form SSA-827: Authorization for Source to Release Information to the SSA

Use this form to authorize your medical sources—doctors, hospitals, clinics, nurses, social workers, family members, friends, governmental agencies, employers and anyone else who has medical information about you—to release information to the SSA. You must complete a separate form for each medical source, plus two additional forms. For example, if you have five medical sources, you will need to complete seven Form SSA-827s. The additional release of information forms are in case other sources of information develop that must be sent a release.



The General and Special Authorization section of Form SSA-827 authorizes release of information pertaining to drug abuse, alcoholism, sickle cell anemia, AIDS and HIV. This authorization is routinely included on the form to speed processing the claim. If you have questions (such as the privacy of your records) regarding this section or any other aspect of Form SSA-827, call 800-772-1213 or contact your local Social Security office.

Here are instructions on how to fill out the form.

1 This section reminds you to read the entire form, front and back.

2 Information About Medical or Other Source. Complete this section only if you have one of the following conditions: drug addiction, alcoholism, sickle cell anemia, AIDS or HIV infection.

3 Signature. The claimant, legal guardian of a child claimant or legal representative must sign each form in the block indicated. If the claimant is not signing,

specify the relationship of the person who is signing—such as parent or legal representative. A child claimant over age 12 should sign in addition to the parent or guardian.

4 Address, Daytime Phone Number and Date. Enter the requested information.

5 Signature of Witness. All forms must be witnessed. Many medical sources will not honor an authorization to release information unless it is witnessed. The witness can be any competent adult, including your spouse, neighbor or a social worker. Include the witness's address.

iv. Forward Forms to the SSA

Once you have completed all the forms, attach copies of any evidence showing that the original determination was incorrect, such as medical records not included in the initial decision. Then fold all forms and documents in thirds, insert them in a standard business envelope and mail to your local Social Security office. If you are not sure where that office is, call 800-772-1213. Keep a copy of each form and the originals of your attached evidence for your records. You may use a nonstandard envelope, if your papers will not fit into a standard one.

b. Reconsideration Appeal Process

A reconsideration is a complete review of your claim. It takes place at the DDS, but by a medical consultant and examiner who were not a part of the initial decision. This means that the claims examiner and medical consultant who had anything to do with the denial of your initial claim are barred from deciding your reconsideration claim. The DDS grants about 5% of all reconsideration claims.

The DDS reconsideration medical consultant and examiner team will look at all the evidence submitted for the original decision plus any new evidence you include with your reconsideration request.

c. Review Your File Before the Reconsideration Decision

To make sure the DDS reconsideration team has all the facts it needs, review your file at the DDS when you file your reconsideration request—before the

Form SSA-827: Authorization for Source to Release Information to the SSA

		TO BE COMPLETED BY SSA	
		NUMBER HOLDER	
		SOCIAL SECURITY NUMBER	
		EMPLOYEE/CLAIMANT/BENEFICIARY <i>(If other than Number Holder)</i>	

AUTHORIZATION FOR SOURCE TO RELEASE
 INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE-PLEASE PRINT, TYPE, OR WRITE CLEARLY		
NAME AND ADDRESS OF SOURCE <i>(Include Zip Code)</i> ② Dr. Paul Dogood 455 Medical Way, Baltimore, MD 43407	RELATIONSHIP TO DISABLED PERSON primary care physician	
INFORMATION ABOUT DISABLED PERSON-PLEASE PRINT, TYPE, OR WRITE CLEARLY		
NAME AND ADDRESS <i>(If known) AT TIME DISABLED PERSON HAD CONTACT WITH SOURCE (Include Zip Code)</i> Myrtle Johnson 2300 Illard Way, Baltimore, MD 43702	DATE OF BIRTH 1/2/1929	DISABLED PERSON'S I.D. NUMBER <i>(If known and different than SSN)</i> <i>(Clinic/Patient No.)</i> A104773
APPROXIMATE DATES OF DISABLED PERSON'S CONTACT WITH SOURCE <i>(e.g., dates of hospital admission, treatment, discharge, etc.)</i> Ongoing from July 1, 1975 to present		

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF									
GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.									
I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:									
1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases; 2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living; 3) Information about how my impairment(s) affected my ability to work.									
I authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.									
I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.									
① READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.									
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%; border-bottom: 1px solid black; vertical-align: bottom;"> SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF ③ Myrtle Johnson </td> <td style="width: 30%; border-bottom: 1px solid black; vertical-align: bottom;"> RELATIONSHIP TO DISABLED PERSON (If other than self) Self </td> <td style="width: 25%; border-bottom: 1px solid black; vertical-align: bottom;"> DATE 1/27/03 </td> </tr> <tr> <td style="border-bottom: 1px solid black; vertical-align: bottom;"> STREET ADDRESS ④ 2300 Illard Way </td> <td colspan="2" style="border-bottom: 1px solid black; vertical-align: bottom;"> TELEPHONE NUMBER (Area Code) </td> </tr> <tr> <td style="border-bottom: 1px solid black; vertical-align: bottom;"> CITY Baltimore </td> <td style="border-bottom: 1px solid black; vertical-align: bottom;"> STATE MD </td> <td style="border-bottom: 1px solid black; vertical-align: bottom;"> ZIP CODE 43702 </td> </tr> </table>	SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF ③ Myrtle Johnson	RELATIONSHIP TO DISABLED PERSON (If other than self) Self	DATE 1/27/03	STREET ADDRESS ④ 2300 Illard Way	TELEPHONE NUMBER (Area Code)		CITY Baltimore	STATE MD	ZIP CODE 43702
SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF ③ Myrtle Johnson	RELATIONSHIP TO DISABLED PERSON (If other than self) Self	DATE 1/27/03							
STREET ADDRESS ④ 2300 Illard Way	TELEPHONE NUMBER (Area Code)								
CITY Baltimore	STATE MD	ZIP CODE 43702							
The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.									
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%; border-bottom: 1px solid black; vertical-align: bottom;"> SIGNATURE OF WITNESS ⑤ </td> <td style="width: 55%; border-bottom: 1px solid black; vertical-align: bottom;"> STREET ADDRESS </td> </tr> <tr> <td style="border-bottom: 1px solid black; vertical-align: bottom;"> CITY </td> <td style="border-bottom: 1px solid black; vertical-align: bottom;"> STATE </td> </tr> <tr> <td style="border-bottom: 1px solid black; vertical-align: bottom;"></td> <td style="border-bottom: 1px solid black; vertical-align: bottom;"> ZIP CODE </td> </tr> </table>	SIGNATURE OF WITNESS ⑤	STREET ADDRESS	CITY	STATE		ZIP CODE			
SIGNATURE OF WITNESS ⑤	STREET ADDRESS								
CITY	STATE								
	ZIP CODE								

Form SSA-827 (1-97) Use Prior Editions EF (3-99)
(OVER)

reconsideration decision is made. If necessary, you can replace inaccurate or missing information. When reconsideration examiners receive additional information from you, they must place it in your file. Your chances of being granted benefits increase if you take an active role in monitoring the DDS's actions.

Call the DDS claims examiner handling your file and set an appointment to review your file. If health or distance make it difficult for you to visit the DDS, designate a representative to review your file (see Chapter 15).

As you review your file, note all problems—inaccurate and missing information. Ask to have pages copied, if necessary. You cannot write directly on records in your file. You can ask that information be added, such as new medical information, and even your own statements about your condition. Don't try to put new information in your file yourself. Give it to the examiner and ask them to put it in your file. Specifically look at the following:

Your medical records. Make sure your important medical records are in the file. If your medical records contain comments by your treating doctor about your disability, note what they say. You or your representative might need to contact your treating doctor for clarification of a statement or to contest a comment you think is inaccurate.

EXAMPLE: Orris has heart disease and is being treated for heart failure. His treating doctor tells the SSA that he can do "light work." When Orris walks a half block, however, he gets short of breath, his heart rate races, he breaks out in a sweat and he gets dizzy. He can't stand for more than ten minutes at a time. Orris takes several medications and the side effects make him feel even worse. The SSA decided he could do light work and used his treating doctor's statement in support. Because of his age, education and work experience, he would have been granted benefits if the SSA had not found that he could do light work. Orris's treating doctor may not know the SSA's definition of light work, which requires lifting up to 20 pounds and standing or walking six to eight hours a day. Orris must talk with his treating doctor, explain the SSA definition of light work, explain that he cannot do it and ask for a

new letter accurately describing his limitations to be used in his reconsideration claim.

Sometimes, a treating doctor doesn't provide information needed by the SSA, even if the doctor has it. For example, your doctor may have described one of your conditions but not another. Or a doctor may provide unclear or inaccurate information. Ask your doctor to forward the necessary information to the DDS. If your treating doctor doesn't have it, the DDS must have you examined at the government's expense through a consultative examination (CE). (See Chapter 5, Section C, for more on CEs.)

It's also possible that your treating doctor provided accurate information, but not enough detail. Although medical judgment determines how much information is enough, sometimes the issues are not clear. For example, suppose your treating doctor said you have arthritis with some pain in certain joints. This isn't enough information to decide the severity of your arthritis. If your doctor can't say more, the DDS should have sent you for CEs to obtain x-rays, evaluate the swelling around your joints, have blood tests done for rheumatoid arthritis and consider how your arthritis limits your ability to carry out your daily activities. Be sure the reconsideration team knows that your complaints were not adequately evaluated, and remind them that you have a right to an adequate medical evaluation of all of your allegations.

Your work records. If the DDS made inaccurate statements about your previous work history, you will need to correct it. Compare your statements on any Form SSA-3369-F6: Vocational Report, or other forms, against those made by the SSA on your denial rationale. If necessary to correct your SSA file, ask your employer or co-workers to submit written information to the DDS.

Form SSA-831: Disability Determination and Transmittal: This form is the official disability determination document used by the DDS. One copy stays with your file. Other copies go to other SSA offices. No copy goes to you. Most of the information on the front of the form will be of little use to you because of the number of codes used by the SSA. But it should contain the name and signature of both the disability examiner and the DDS medical consultant who worked on your claim.

DDS Medical Consultant Codes

The type of doctor who reviewed your file is referred to by a code on your file. Here is a list of the codes and the type of doctor it refers to:

1 Anesthesiology	25 Obstetrics
2 Ambulatory Medicine	26 Occupational Medicine
3 Audiology	27 Oncology
4 Cardiology	28 Ophthalmology
5 Cardiopulmonary	29 Orthopedics
6 Dermatology	30 Osteopathy
7 E.E.N.T. (Eyes, Ears, Nose & Throat)	31 Pathology
8 E.N.T. (Ear, Nose & Throat)	32 Pediatrics
9 E.T. (Ear & Throat)	33 Physiatry
10 Emergency Room Medicine	34 Physical Medicine
11 Endocrinology	35 Plastic Surgery
12 Family or General Practice	36 Preventative Medicine
13 Gastroenterology	37 Psychiatry
14 Geriatrics	38 Psychology
15 Gynecology	39 Public Health
16 Hematology	40 Pulmonary
17 Industrial Medicine	41 Radiology
18 Infectious Diseases	42 Rehabilitative Medicine
19 Internal Medicine	43 Rheumatology
20 Neurology	44 Special Senses
21 Neuroophthalmology	45 Surgery
22 Neuropsychiatry	46 Urology
23 Neonatology	47 Other
24 Nephrology	

Attached to Form SSA-831 or on Form SSA-4268: Explanation of Determination, should be the technical rationale used in making your disability determination. Because the technical rationale contains a lot more detailed information than the personalized explanation rationale you were sent with your denial notice, it is in your interest to look it over, even though it may include bureaucratic language you do not understand. By reviewing the technical rationale, you can see the step-by-step reasoning that the SSA used to deny your claim. The DDS examiner handling your claim writes these rationales. (See Appendix B for examples of technical rationales.) Note the name of the medical consultant who signed the SSA-831 and the number of the specialty code near his or her name. Such specialty code information can be very valuable in demonstrating that the wrong kind of doctor reviewed your claim. For instance, child or adult mental impairments should always be evaluated by a psychiatrist or psychologist, and children's claims about physical impairments should always be evaluated by a pediatrician.

Residual functional capacity (RFC) forms: RFC forms may not be in your file if your claim was denied because your impairments were considered not severe (mild or slight). Your file may contain physical RFCs (Form SSA-4734-U8: Residual Functional Capacity Assessment), mental RFCs (Form SSA-4734-F4-SUP: Mental Residual Functional Capacity Assessment) or both.

Check the RFC forms to make sure that the information is actually true. Note the limitations and abilities the medical consultant (MC) gave you. Do you agree with them? Do they contradict your treating doctor? Did the MC say you have more exertional ability (such as lifting, carrying, walking) than your treating doctor says you have? Did the MC fail to give you limitations suggested by your treating doctor, such as avoiding excessive fumes or restrictions on frequent bending of your back? Did the MC attribute to you mental abilities you do not have—such as the ability to complete tasks in a timely manner? If the MC's RFC does not agree with your treating doctor's evaluation, the MC must provide an explanation on the RFC form describing why your doctor's recommendations were not used. (See Chapter 8 for more on RFCs.)

Form SSA-2506-BK: Psychiatric Review Technique

Form (PRTF): If you have a mental condition, this form should be in your file. It is supposed to assure that

the DDS psychiatrist or psychologist considers all of the important information about your mental impairment. The PRTF contains the following:

- Dates covered by the assessment, the MC's signature and the date signed.
- Section I should contain a medical summary.
- Section II should include the MC's record of pertinent signs, symptoms, findings, functional limitations and effects of treatment that have a significant bearing on your case. This Section should also include the MC's reasoning about why you received a particular medical determination.
- Section III should include the MC's record of signs, symptoms and findings that show the presence of the categories of mental disorders in the Listing of Impairments.
- Section IV should include the MC's rating of functional limitations, which are relevant to your ability to work.

Look for errors on the PRTF, such as incorrect dates or incorrect diagnosis of your mental condition, or statements that contradict those of your treating psychiatrist or psychologist. Did the MC state that you have had no episodes of worsening in your mental condition affecting your ability to work when in fact you did—for example, did you have to leave work or were you unable to work for certain periods of time because of worsening symptoms?

Who made the medical determination? It is important for you to establish that an MC reviewed your file and made the medical determination about what you can and cannot do. Here's how to do that:

- **MC review notes.** An MC's medical notes demonstrate her thinking, interpretation of test results, recommendations on medical development and statements about medical severity. Did the MC make erroneous statements? Does your file lack MC notes completely? If the DDS concluded that you do not have severe impairments, but your file lacks MC notes showing that an MC came to that conclusion by reviewing your file, the fact that an MC signed the disability determination form is no assurance that the MC performed a review of your file. In such a situation, be highly suspicious. Your denial may have been made by the DDS examiner, not the MC. Insist on a

review by an MC. (See Chapter 6 for suggestions on how to demand that an MC review your file.)

- **RFC forms.** Note the name of the MC who signed the RFC form. Is the handwriting the same as on the other parts of the form—that is, did the doctor actually complete the form? If not, the MC may have simply signed an RFC completed by the examiner. Legally, you have the right to have a medical determination by an MC. An MC's signature is supposed to assure that your file was medically reviewed. But, in reality, this is not always the case. Insist that an MC review your claim, if there is any question that was not done. (See Chapter 6 for suggestions on how to demand that an MC review your file.)

d. Reconsideration Decision

If your claim is denied again, you will receive a denial notice and explanation very much like the one you received when your initial claim was denied. The only difference is that the DDS should have evaluated any new evidence and new allegations you presented. The next level of appeal, if you want to pursue it, would be to request a hearing before an administrative law judge. (See Section D3.)



Beware of Copycat Reconsiderations

When you appeal a claim to the DDS for reconsideration, the medical consultant and the examiner selected to review your file must be different from those who denied your initial claim. This doesn't mean the new DDS team will do a thorough examination. A few examiners and MCs are copycats who rubber-stamp claims—simply copy the initial denial determination instead of doing another review.

If your reconsideration is denied and you presented new evidence or had new issues you wanted considered, visit the DDS and look at your file. Check the technical rationale and MC review notes to make sure the DDS did not ignore the new information. If it looks like your claim was rubber-stamped by a copycat, demand that it be recalled and that the new medical and nonmedical evidence be considered. You have a right to request such a reopening (see Section E), which can be accomplished by a telephone call or letter to the DDS director. If the DDS refuses, you have an even stronger basis for appeal.

2. Request for Reconsideration of Continuing Disability Claim

Once you begin receiving disability benefits, your case is re-examined periodically through a continuing disability review (CDR). (See Chapter 14 for more on this subject.) The SSA can end your benefits for a variety of reasons, including:

- a determination that your condition has improved and you can now work, or
- your failure to cooperate in the CDR.

This decision to terminate your benefits is made by a DDS medical consultant and examiner team.

You will receive a notice and explanation from the SSA explaining why your benefits are being terminated. The language of the notice should include something similar to the following words:

We are writing to tell you that we have looked at your case to see if your health problems are still disabling. After looking at all of the information in your case carefully, we found that you are not disabled under our rules as of (month/year).

The notice will come with a brief explanation of your medical condition and of how the SSA reached its decision. If you want to appeal, you must request a reconsideration of a CDR at a hearing before a disability hearing officer (DHO). If you appeal, before your claim goes to the hearing officer it will receive a second review by a different DDS medical consultant and examiner who could reverse the prior CDR decision to terminate your benefits (see Section b, below.)

Remember that although the DHO is not a doctor or a psychologist, they are allowed to form their own medical opinions about the severity of your physical or mental impairments. In fact, some DHOs reverse half the CDR denial (termination) cases they see, saving the claimant's benefits. They are often not hesitant to disregard the judgments of two different DDS medical consultant/examiner teams who thought your benefits should stop. So, there is a fairly good chance your benefits will be continued, and you have nothing to lose by trying.

As you prepare for the DHO hearing, keep in mind that the SSA must have good evidence that you have had significant work-related medical improvement—except for certain exceptions discussed in Chapter 14. At your DHO hearing, this is the critical issue. And it is a matter of medical judgment, for which your treating doctor's judgment should carry great weight. If your case is borderline, your benefits should continue.

a. Complete the Forms

To request a reconsideration determination by a disability hearing officer, you must file Form SSA-789-U4: Request for Reconsideration—Disability Cessation, with your local Social Security Field Office. If many months pass between when your CDR began and your hearing with a DHO, you can update the information you originally provided on the SSA Form 454-BK with Form SSA-782-BK, which you must request from your local Social Security Field Office. It is not available from the DDS.

i. Form SSA 789-U4: Request for Reconsideration—Disability Cessation:

Form SSA 789-U4 is easy to complete, and your local Field Office will be happy to help with any questions you have. The form is completed by the SSA repre-

sentative in the Field Office when you request reconsideration of disability cessation. The form is a multi-copy form separated by carbon paper. We include instructions and a sample form below.

The top of the form asks for the claimant's name and Social Security number (SSN). If the wage earner is different than the claimant, then the name of that person is required, along with their SSN. If your claim is an SSI case, there is a blank requiring your spouse's name and SSN. The blank space in the upper right-hand corner is called "For Social Security Office Use Only," but has some important little boxes in it. One box allows you to request notices in Spanish. Another is to be checked if you want your benefits to continue during your appeal. Continuation of benefits only applies to appeals before the SSA; you cannot continue to receive benefits while appealing to a federal court.

Getting Benefits During an Appeal

If you want your benefits to continue during appeals before the Disability Hearing Officer (DHO), Administrative Law Judge or the Appeals Council, you have only ten days from the time you receive the CDR benefit cessation notice to file your appeal. The CDR benefit termination notice (see Chapter 14) will remind you of this fact. Since the SSA allows five days for mailing time, a more accurate way to count the days you actually have is to add 15 days to the date on the cessation notice.

If you continue benefits through your appeals and lose, you may have to repay the SSA. If you do decide to continue your benefits during appeals, you should also file Form SSA-632-BK: Request for Waiver of Overpayment, with your local Social Security Field Office. One of the exemptions for having to repay benefits is if you are unable to do so. Even if you eventually have to pay back some benefits, the amount can be as small as \$10 per month.

The next set of blanks concerns the type of benefit involved in your claim. There are boxes under "Disability" (SSDI claims) and SSI. Those that apply must be checked.

You are next asked for the name and address of any authorized representative you might have, as well as their telephone number.

Next, the form asks for the specific reasons you don't agree with the determination to stop your benefits. Remember, this is just a form to get your appeal started. You don't need to make long arguments here—just the basic facts. For example, you might say, "My arthritis has not improved, and the decision to stop my benefits ignored the opinion of my treating doctor that I have not gotten better. I have additional information from my doctor showing that I have not improved."

Then the next line lets you refer to any additional information, such as "New medical records and opinion from my treating doctor." Then give your doctor's name and address. If there is not enough room, the Social Security representative will enter it onto additional pages.

The form then has check boxes asking if you wish to appear at the disability hearing with a DHO, and whether you have or need an interpreter provided by the SSA. If you can only make an "X" for a signature, two witnesses who know you will also have to sign as well as provide their addresses. You will also be required to provide your address. Make sure it is an address where the SSA can reach you.

As discussed above, Form SSA-789 lets you waive your right to personally appear at the hearing. Another SSA form is also used to waive the right to personally appear at the hearing (Form SSA-773), and the DHO may ask you to sign Form SSA-773 to assure that you understand what it means to waive your rights. Form SSA-773 contains language explaining the nature and importance of the rights you waive when you sign Form SSA-773 or the waiver section of Form SSA-789:

I have been advised of my right to have a disability hearing. I understand that a hearing will give me an opportunity to present witnesses and explain in detail to the disability hearing officer, who will decide my case, the reasons why my disability benefits should not end. I understand that this opportunity to be seen and heard could be effective in explaining the facts in my case, since the disability hearing officer would give me an opportunity to present and question witnesses and explain how my impairments prevent me from working and restrict my activities. I have

been given an explanation of my right to representation, including representation at a hearing by an attorney or other person of my choice.

Although the above has been explained to me, I do not want to appear at a disability hearing, or have someone represent me at a disability hearing. I prefer to have the disability hearing officer decide my case on the evidence of record plus any evidence that I may submit or which may be obtained by the Social Security Administration. I have been advised that if I change my mind, I can request a hearing prior to the writing of a decision in my case. In this event, I can make the request with any Social Security office.

You do not want to waive your right to attend a hearing unless it will be impossible for you to attend. The hearing gives you the chance to personally explain to the DHO why you believe you are still disabled. Also, the hearing officer may notice something about you that is not obvious from the medical file which supports your contention that you are still disabled.

ii. Form SSA-782-BK: Reconsideration Report for Disability Cessation:

This form is very much like the Form SSA-454-BK you completed at the beginning of the continuing disability review. (See Chapter 14 for information on filling out Form SSA 454-BK.) You need to complete it only to include new developments or corrections since completion of Form SSA-454-BK—for example, if you saw new doctors or received additional medical treatments. See the sample of this form below.

b. DDS Review

Before the Disability Hearing Officer considers your case, a new DDS team (consisting of a medical consultant and a DDS examiner) will review the decision to terminate your benefits. The purpose of the new review is to see if your benefits can continue without the inconvenience of a hearing. The second team might reverse the first team and grant you a continuation of your benefits, either because they think the first team is in error or if the DDS received important additional information that influences the determination. In that case, the hearing is no longer necessary.

Form SSA-789-U4: Request for Reconsideration—Disability Cessation

SOCIAL SECURITY ADMINISTRATION

TOE 710

Form Approved
OMB No. 0960-0349**REQUEST FOR RECONSIDERATION —
DISABILITY CESSATION**

(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)

FOR SOCIAL SECURITY OFFICE USE ONLY
(DO NOT WRITE IN THIS SPACE)

NAME OF CLAIMANT

Howard E. Walker

SOCIAL SECURITY NUMBER

888-88-8888

NAME OF WAGE EARNER OR SELF EMPLOYED PERSON
(IF DIFFERENT FROM CLAIMANT)

SOCIAL SECURITY NUMBER

SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE **ONLY** IN
SUPPLEMENTAL SECURITY INCOME CASE)

Helen Walker

777-77-7777

☐ BENEFIT CONTINUATION DO CODE _____
☐ SPANISH NOTICES DCS CODE _____
☐ IMPAIRMENT CODE DHU CODE _____

TYPE OF BENEFIT	DISABILITY			SSI		
	☐ WORKER	☐ WIDOW	☐ CHILD	☐ DISABILITY	☐ BLIND	☐ CHILD

NAME OF REPRESENTATIVE, IF ANY

Susan Sullivan

REPRESENTATIVE'S ADDRESS

1919 Grove Street, Bakersfield, IL 60500

TELEPHONE NUMBER (INCLUDE AREA CODE)
(708) 555-1111

I do not agree with the determination to stop disability benefits and I request reconsideration. My reasons are:
REASONS SHOULD RELATE TO BASIS FOR CESSATION AND BE AS SPECIFIC AS POSSIBLE

NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice of the determination.

There has been no significant improvement in my impairments. Furthermore, the DDS ignored my treating doctor's opinion about my physical and mental abilities.

I AM SUBMITTING THE FOLLOWING ADDITIONAL INFORMATION (IF "NONE" WRITE "NONE").

Russell Crane, M.D.—see attached records

CHECK ONLY ONE OF THE FOLLOWING STATEMENTS:

☒ I WISH TO APPEAR AT THE DISABILITY HEARING (INCLUDES REPRESENTATIVE APPEARING FOR THE CLAIMANT).

IF "YES" INDICATE LANGUAGE AND CHECK ONE:

I NEED AN
INTERPRETER☐ YES☒ NO☐ I WILL PROVIDE
INTERPRETER☐ SSA NEEDS TO
PROVIDE INTERPRETER

☐ I do not wish to appear nor do I wish a representative to appear for me at the disability hearing. I understand that a decision will be made based on the evidence in my claim.

Witnesses are required **ONLY** if this form has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS

2. SIGNATURE OF WITNESS

ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)

ADDRESS (NUMBER AND STREET, CITY, STATE, ZIP CODE)

**SIGN
HERE**

SIGNATURE (FIRST NAME, MIDDLE INITIAL, LAST NAME)

Howard E. Walker

MAILING ADDRESS (NO. & ST., APT. NO., P.O. BOX OR RURAL RT.)

P.O. Box 1928

CITY AND STATE

Bakersfield, IL

ZIP CODE

60500

(WRITE IN INK)

DATE (MONTH, DAY, YEAR)

1-25-2003

TELEPHONE NUMBER (INCLUDE AREA
CODE)

(708) 555-2222

Form SSA-782-BK: Reconsideration Report for Disability Cessation (Page 1)

SOCIAL SECURITY ADMINISTRATION RECONSIDERATION REPORT FOR DISABILITY CESSATION		OFFICE REPORT MADE ☐ IN PERSON ☐ TELEPHONE	DATE PLACE OF REPORT ☐ FO ☐ CONTACT STATION ☐ HOME ☐ OTHER
WAGE EARNER'S NAME <i>Anne Brown</i>	SOCIAL SECURITY NUMBER <i>555 155 5555</i>	BENEFICIARY'S NAME IF NOT WAGE EARNER	SOCIAL SECURITY NUMBER ____ / ____ / ____
PERSON REPORTING ☐ BENEFICIARY ☒ OTHER PERSON (Show name, address, relationship, and why beneficiary is not reporting.)			
NAME <i>Sam Brown</i>		RELATIONSHIP <i>Husband</i>	
ADDRESS (Number and Street, City, State and ZIP Code) <i>472 11th Street, Denver, CO 80299</i>		WHY BENEFICIARY IS NOT REPORTING <i>my wife is too ill</i>	
TYPE OF BENEFIT	DISABILITY ☐ WORKER ☐ WIDOW ☐ CHILD	SSI ☐ DISABILITY ☐ BLIND ☐ CHILD	
Paperwork/Privacy Act Notice: The Social Security Administration is authorized to collect the information on this form under sections 205(a), 1631(e)(A) and (B), and 1872 of the Social Security Act, as amended (42 U.S.C. 405, 1383 and 1395ii). Giving us the information on this form is voluntary. However, if you do not respond, we will make a decision based on the evidence in your file. The Social Security Administration will use the information on this form to fully evaluate your claim for disability benefits. We may routinely give out the information on this form without your consent if: 1. We need to get more information to decide if you are eligible for benefits; 2. An agency needs this information to decide if you are eligible for a health or income program such as SSI State supplementary payments, food stamps, Medicaid, energy assistance, Veterans benefits, or Basic Education Opportunity Grants; 3. A Federal law requires that we give out this information; 4. Your Congressman or the President's Office needs this information to answer questions you ask them; 5. Someone needs this information to do statistical research or audit reports for us related to the Social Security programs; or; 6. The Department of Justice needs the information to represent the Federal Government in a court suit related to SSA administered programs. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 30 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.			
PLEASE USE THIS FORM TO PROVIDE INFORMATION ABOUT YOUR DISABLING CONDITION THAT YOU DID NOT GIVE US ON YOUR LAST REPORT OF CONTINUING DISABILITY INTERVIEW (SSA-454-BK). NOTE: All information must reflect the beneficiary's (or his/her representative's) statements regarding the disabling condition since the last interview; i.e., the continuing disability interview. Changes in the condition and other new information as well as any corrections/additions to information previously provided should be included. This report will be one source of information used to reconsider the determination that disability has ceased.			
PART I - INFORMATION ABOUT YOUR CONDITION			
1. a. What is your disabling condition? (Briefly summarize all injuries or illnesses and tell how they prevent you from working?)			
<i>My wife has chronic schizophrenia, and has been unable to work for the past 15 years.</i>			
<i>Her lack of concentration, decreased memory, and difficulty relating to other people</i>			
<i>make it impossible for her to work. I and other family members must closely supervise</i>			
<i>and care for Anne. Her condition has not improved, contrary to what the DDS said.</i>			
b. Has there been any change (for better or worse) in your disabling condition since your last disability interview?		☐ Yes ☒ No	
If "yes," describe any changes.			
c. Do you have any new injuries or illnesses?		☐ Yes ☒ No	
If "yes," describe any changes.			
2. a. Do you feel you are able to return to work?		☐ Yes ☒ No	
If "yes", explain and describe any limitations in Part VI which were not previously provided. If "no", explain in Part VI if you have not already told us why.			

Form SSA-782-BK: Reconsideration Report for Disability Cessation (Page 2)

2.	b. Has your doctor told you that you are able to return to work? If "yes", answer items c, d and e.	☒ Yes ☐ No ☐ Did Not Say
Cont.	c. List the name and address of the doctor(s) who told you to return to work.	
	NAME Anne Miller	d. What date did your doctor tell you that you could return to work? → MONTH-DAY-YEAR 3/1/03
	ADDRESS (Number and Street, City, State and ZIP Code) 477 21st St., Denver, CO 80289	e. Did the doctor restrict you to limited or part-time work? (If "yes," explain in Part VI.) ☒ Yes ☐ No
PART II - INFORMATION ABOUT YOUR MEDICAL RECORDS		
NOTE: When completing Part II, provide a summary of medical examinations and treatments not provided previously. If you have not seen a doctor, check here → ☐		
3.	List the name, address and telephone number of any doctor(s) you have seen.	
	a. NAME Dr. Claudia Edwards	TELEPHONE NUMBER (Include area code)
	ADDRESS (Number and Street, City, State and ZIP Code) 10001 Forest View Drive, Denver, CO 80255	303-555-9999
	How often do you see this doctor? Every 3 months	Date you first saw this doctor (Month, Day, Year) 1987
		Date you last saw this doctor (Month, Day, Year) March 13, 2003
	Reasons for visits (show illness or injury for which you had an examination or treatment) Dr. Edwards is a psychiatrist who treats Anne's schizophrenia.	
	Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE") Medication (Clozaril). Mental check-ups and blood tests.	
	b. NAME	TELEPHONE NUMBER (Include area code)
	ADDRESS (Number and Street, City, State and ZIP Code)	
	How often do you see this doctor?	Date you first saw this doctor (Month, Day, Year)
		Date you last saw this doctor (Month, Day, Year)
	Reasons for visits (show illness or injury for which you had an examination or treatment)	
	Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")	
4.	List any hospitalizations or treatments at a clinic for your disabling condition.	
	NAME OF HOSPITAL OR CLINIC Colorado General Hospital, Psychiatric Unit	PATIENT OR CLINIC NUMBER Don't know
	ADDRESS (Number and Street, City, State and ZIP Code) 3201 W. Colfax Avenue, Denver, CO 80289	
	Were you an inpatient (i.e., stayed at least overnight)? ☒ Yes ☐ No If "yes," show below.	Were you an outpatient? ☒ Yes ☐ No If "yes," show below.
	DATES OF ADMISSIONS	DATES OF DISCHARGES
	1987	1987
	1994	1994
	May 2000	June 2000
	DATES OF VISITS	
	NA	
	NA	
	NA	

Form SSA-782-BK: Reconsideration Report for Disability Cessation (Page 3)

4. Reason for hospitalization or clinic visits (show illness or injury for which you had an examination or treatment)

Cont.

Worsening of schizophrenia in 1993 and 1999, after initial diagnosis in 1987.

Type of treatment or medicine received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")

Medication and other supportive therapies to improve illness and allow discharge from hospital.

5. List other agencies which have seen you for your injury or illness. (VA, Worker's Compensation, Vocational Rehabilitation, Public Assistance)

NAME OF AGENCY	YOUR CLAIM NUMBER
ADDRESS (Number and Street, City, State and ZIP Code)	TELEPHONE NUMBER (Include area code)
DATES OF VISITS (Month, Day, Year)	TYPES OF TREATMENTS OR EXAMINATION RECEIVED

If more space is needed, list in Part VI the other agencies, their addresses, your claim numbers, dates and treatment received.

6. INDICATE ANY OF THE FOLLOWING TESTS YOU HAVE HAD	IF CHECKED SHOW	
	WHERE DONE	WHEN DONE
☐ EKG - Resting		
☐ EKG- Treadmill		
☐ Chest x-ray		
☐ Other x-ray (specify ▶)		
☐ Breathing tests		
☒ Blood tests	Hospital and Dr. Edwards Office	periodically to monitor drug effects
☒ Other (specify ▶) mental tests	Hospital	1986
☐ Other (specify ▶)		
☐ Other (specify ▶)		
☐ Other (specify ▶)		

PART III - INFORMATION ABOUT YOUR ACTIVITIES

7. Describe any limitations your doctor placed on your activities not reported previously. Give the name of the doctor below and tell what he or she told you about limiting your activities:

Dr. Edwards said Anne must be closely supervised and must avoid mental stress. Her symptoms worsened in 1994 and 2000 after she tried to return to work, and she had to be hospitalized. Dr. Edwards emphasized we must provide a highly supportive home for Anne.

Form SSA-782-BK: Reconsideration Report for Disability Cessation (Page 4)

8. Describe your daily activities in the following areas and state what and how much you do of each; how often you do it; and any assistance you require. Provide only information which differs from that reported previously.

PERSONAL MOBILITY (walking, moving about, exercising your legs, etc.)

Anne has no problems in this area.

PERSONAL NEEDS AND GROOMING (dressing, bathing, etc.)

Anne sometimes needs to be reminded to bathe and will wear her clothes in a bizarre way if not supervised. She doesn't seem very interested in her appearance.

HOUSEHOLD MAINTENANCE (cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

Our daughters do most of the cooking and cleaning. Anne can do simple things like making a sandwich or bowl of soup, or doing a little dusting. But she often refuses to help with chores, saying that she's "just not interested."

RECREATIONAL ACTIVITIES AND HOBBIES (TV, radio, newspapers, books, fishing, bowling, musical instruments, etc.):

Most days Anne watches TV. Her previous interests have been gone for years. She will go with us on family outings, but never suggests anything to do herself.

SOCIAL CONTACTS (visits with friends, relatives, neighbors, church, social clubs):

Anne is not interested in social activities. When friends or relatives visit, she does not interact well—she seems subdued emotionally and her attention drifts off when others talk to her. She can only carry on simple conversations.

OTHER (drive car, motorcycle, ride bus or subway, etc.):

Anne does not drive any more. It makes her too nervous, as does any traveling alone.

Form SSA-782-BK: Reconsideration Report for Disability Cessation (Page 5)

9. LIST ANY (TRADE, VOCATIONAL OR ACADEMIC) SCHOOL(S) OR ANY OTHER TYPE OF VOCATIONAL TRAINING YOU HAVE NOT ALREADY TOLD US ABOUT.

None

10. List any school you are now attending if not previously provided.

NAME OF SCHOOL

ADDRESS OF SCHOOL (Number and Street, City, State and ZIP Code)

CURRENT GRADE

PART IV - INFORMATION ABOUT THE WORK YOU DID

WHEN COMPLETING PART IV PROVIDE INFORMATION SINCE DATE YOU BECAME DISABLED

11. Since you became disabled, have you done work that was not previously reported? ☐ Yes ☒ No

If "yes," complete the following for each work attempt, no matter how short it was.

JOB TITLE (Be sure to begin with your usual job)	TYPE OF BUSINESS	DATES WORKED (month/year)		DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)
		FROM	TO		
					\$
					\$
					\$
					\$

12. Describe your basic duties (explain for each job listed above what you did and how you did it) below. Also, explain why you stopped working for each work attempt listed in Item 11.

NA

PART V - INFORMATION ABOUT REHABILITATION SERVICES

13. VOCATIONAL REHABILITATION IMPORTANT: Even if it is determined that you are not disabled, you may be eligible for continued payments if you are in an approved vocational rehabilitation program and meet other requirements of the law.

a. Describe any help you are receiving, such as services, training or counseling from a State vocational rehabilitation agency or any other vocational rehabilitation program not provided previously.

None currently. I question whether this would help Anne.

b. List any type of training you expect to receive, if not provided previously.

NA

Form SSA-782-BK: Reconsideration Report for Disability Cessation (Page 6)

13.	c. Indicate the name, address and phone number of your VR counselor, and the State VR agency or other VR service provider, if not provided previously.		
Cont.	NAME	ADDRESS (Number and Street, City, State and ZIP code)	TELEPHONE NUMBER (Include area code)
PART VI - REMARKS			
14.	Use this section for additional space to answer any previous questions. Also, use this space to give any additional information that you think will be helpful in the review of the continuing entitlement to Social Security disability benefits. (If you need more space, use a separate sheet of paper. Also, if you wish, you may attach any evidence that shows your current condition.)		
	<i>Anne has a severe chronic mental disorder. She can function minimally under the supervision and support of our whole family. Contrary to what the DDS states, Anne's mental condition has not significantly improved. Her benefits were continued multiple times in past reviews. Although nothing has changed, the DDS now says she's improved and can work. This is wrong, as shown by medical records and Dr. Edward's opinion.</i>		
PART VII - AUTHORIZATION AND NOTIFICATION STATEMENTS			
I understand that this report will be used to determine whether to continue or to stop my disability benefits. I also understand that if I am receiving Social Security disability benefits and Supplemental Security Income payments, this questionnaire is applicable to both claims.			
▶ Copies of medical records may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary. ▶ Results of any such independent examination may be provided to my personal physician. ▶ Medical information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service. ▶ The State Vocational Rehabilitation Agency may review any medical evidence for determining my eligibility for rehabilitative services. ▶ I agree to notify the Social Security Administration if my medical condition improves or I go to work. ▶ I know that anyone who makes a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law. I affirm that the above statements are true.			
SIGNATURE OR CLAIMANT OR PERSON FILING ON THE CLAIMANT'S BEHALF		DATE (Mo., Day, Yr.)	TWO TELEPHONE NUMBERS WHERE CLAIMANT CAN BE REACHED (INCLUDE AREA CODE)
SIGN HERE ▶ <i>Sam Brown</i>		<i>April 4, 2003</i>	<i>303-555-0000</i>
MAILING ADDRESS (Number and Street, Apt. No., P.O. Box or Rural Route)			
<i>472 11th Street</i>			<i>303-555-1111</i>
CITY AND STATE			ZIP CODE
<i>Denver, CO</i>			<i>80299</i>
Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below giving their full addresses.			
1. SIGNATURE OF WITNESS		2. SIGNATURE OF WITNESS	
ADDRESS (Number and street, city, state, and ZIP code)		ADDRESS (Number and street, city, state, and ZIP code)	

Form SSA-782-BK: Reconsideration Report for Disability Cessation (Page 7)

PART VIII - FOR SSA USE ONLY - DO NOT WRITE BELOW THIS LINE

NAME OF CLAIMANT

SOCIAL SECURITY NUMBER

15. a. Check each item to indicate if any difficulty was observed:

	Yes	No		Yes	No
Breathing	☐	☐	Use of hands and arms	☐	☐
Sight	☐	☐	Writing	☐	☐
Speaking	☐	☐	Reading	☐	☐
Hearing	☐	☐	Comprehending	☐	☐
Sitting	☐	☐	Responding	☐	☐
Walking	☐	☐	Relating to people	☐	☐
Standing	☐	☐	Other (specify)	☐	☐

b. If any of the above items were checked "yes", describe the exact difficulty involved.

c. Describe the claimant fully (e.g., general build, height, weight, behavior, any difficulties that add to or supplement those noted above). Indicate any other noticeable physical/mental limitations/ impairments. Also, indicate any unusual circumstances surrounding the interview, e.g., how claimant came to the FO for the interview, lack of difficulty where it might be expected.

On the other hand, if the second team decides that the decision to terminate your benefits was correct, the second team will send an advisory rating decision to the DHO stating that you be considered medically improved and capable to performing some type of work.

c. Review Your File Before the Hearing

You want to review four categories of documents in your file.

Work activity records. Review Section D1c, above, for an explanation of what to look for.

Your medical records, including any letters sent to the DDS by your treating doctor. See Section D1c.

RFC forms. Section D1c contains an explanation of what to look for.

Technical rationale. Technical rationales are internal SSA forms containing long explanations of DDS decisions. Section D1c contains an explanation of them; examples are in Appendix B. The technical rationale will be on Form SSA-4268: Explanation of Determination or on one of the following forms:

- Form SSA-833-U3: Cessation or Continuance of Disability or Blindness Determination and Transmittal (SSDI)
- Form SSA-834-U3: Cessation or Continuance of Disability or Blindness Determination and Transmittal (SSD).

Look also for the SSA-831 and an associated rationale from your initial disability determination. This form helps you understand the DDS's reasoning in saying that you are no longer disabled.

d. Attend Hearing With a Disability Hearing Officer

Disability Hearing Officers are not medical doctors or psychologists, and do not need to have any formal medical training. Some DHOs are experienced disability examiners or examiner supervisors promoted into a DHO position, and given administrative training on how to conduct hearings.

When the DHO receives your appeal, the DHO may allow your claim for continued benefits without requiring a hearing. If so, you will receive a notice to that effect. Otherwise, the DHO will send you a notice with the hearing date and location. If the DHO's office

is far from your home, you can call the DHO's office to ask for a location closer to you. The notice will have the DHO's telephone number, which you can also obtain from your local Social Security office.

Before the hearing, the DHO will send you a notice asking for a list of the people you expect to attend the hearing with you, including witnesses or a representative, such as a lawyer. Witnesses, including your spouse, other relatives and friends who are knowledgeable about your limitations, can testify that your activities continue to be severely limited. This would be very helpful to your claim. You cannot bring spectators to the hearing. If you bring people who have no legitimate reason to be present, the DHO has the authority to ask them to leave.

A hearing with a DHO is informal. The room won't look anything like a courtroom. Chances are you will sit at a large table with the DHO and your representative or attorney, if any. However, the DHO will make sure that your hearing takes place in privacy. There will be no one there arguing against your claim.

DHOs may vary somewhat in how they handle hearings. However, they all must deal with any new evidence you have regarding your jobs and work experience, your medical impairments, your treating doctor's opinions and your statements why you think the cessation determination was wrong. The DHO must make sure that all of your allegations have been adequately developed in your file. The DHO should introduce herself and make sure that each person's name and purpose in being there is understood. She should then briefly go over the way she expects the hearing to proceed. You will undoubtedly be asked why you think your benefits should not be terminated.

You have the right to ask questions during the hearing, and you'll want to ask the DHO what significant medical improvement the SSA claims you have experienced that allows you to work and what level of work the SSA claims you can do. (Levels of work are explained in Chapters 8 and 9.) If you or your representative reviewed your file before the hearing, show the DHO why the DDS documents are in error. For example, can you demonstrate that your medical records show no significant medical improvement or that your improvement doesn't mean you are well enough to return to the types of jobs recommended in the termination notice?

After the hearing, expect a written decision from the DHO within a few weeks. If you are again denied, you will receive a denial notice and explanation similar to those you received in your previous denials. If you disagree with it, you can appeal to an administrative law judge. Your benefits can continue during appeal. However, read the sidebar “Getting Benefits During an Appeal” at Section D2.

3. Appeal to Administrative Law Judge

If your request for reconsideration (of an initial claim or continuing disability review termination) is denied and you want to appeal further, you must request a hearing before an administrative law judge (ALJ) within 60 days from receipt of your denial. Since the SSA adds five days for mailing time, you actually have 65 days from the date on your denial notice. Your benefits can continue through the ALJ hearing process, if you choose that option when submitting your hearing request. But, if you lose your appeal, you will have to repay the benefits you received during that time (see sidebar in Section D2, above). The ALJ is likely to dismiss your case if you file your appeal notice later without good reason for doing so. (The ALJ can dismiss your case for other reasons as well, but these are not likely to be an issue in your case.)

ALJs are attorneys who work for the SSA’s Office of Hearings and Appeals (HA). HA is entirely separate from the division that evaluates initial applications, continuing disability reviews and reconsideration claims. ALJs are not like judges who work in the civil and criminal courts. ALJs’ powers reside only within the SSA. Most of their work involves upholding or overturning a decision by a DDS to deny or terminate disability benefits; they also hold hearings on non-disability Social Security issues. There is no jury in an ALJ hearing; the ALJ, alone, makes the decision to allow or deny you benefits.

You might think that an ALJ’s decision would be very similar to the DDS or hearing officer’s because they both work for the SSA. Nothing could be further from the truth. ALJs usually pay little attention to DDS determinations. Because ALJs are not physicians, however, it is sometimes difficult for them to evaluate medical information and decide which medical opinions

in a claimant’s file are the most accurate. Although ALJs can ask consulting medical experts to help them evaluate medical information, this is infrequently done. Some ALJs grant or continue benefits when a DDS doctor has said that there is very little wrong with a claimant. Overall, ALJs grant about 67% of the claims that reach them. Some ALJs allow 99% of claims they see.

a. Complete the Forms

To request an ALJ hearing, you need three forms:

- Form HA-501-U5: Request for Hearing by Administrative Law Judge
- Form HA-4486: Claimant’s Statement When Request for Hearing Is Filed and the Issue Is Disability, and
- Form SSA-827: Authorization for Source to Release Information to the Social Security Administration (see Section D1a).



You must use forms provided by the SSA. You can obtain them at your local SSA Field Office or by calling the SSA hotline at 800-772-1213, Monday through Friday (except holidays), from 7 a.m. to 7 p.m. If you are deaf or hard of hearing, TTY service representatives are available at the same times at 800-325-0778. You can also download many necessary forms from the Social Security Administration website at www.ssa.gov. They are not available from the DDS.

i. Form HA-501: Request for Hearing by Administrative Law Judge

This is the form you use to request a hearing before an administrative law judge. Instructions and a completed sample follow.

1 Name of Claimant: Enter your name or the name of another person on whose behalf this appeal is being filed.

2 Name of Wage Earner or Self-Employed Individual: Enter your name or the name of the person on whose record you received Social Security benefits.

3 Social Security Claim Number: Enter the Social Security number of the wage earner identified in number 2 with the appropriate suffix—such as HA, B2, C1 or D. It is on all correspondence you receive from the SSA.

Form HA-501-U5: Request for Hearing by Administrative Law Judge

SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALSForm Approved
OMB No. 0960-0269**REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE**
[Take or mail original and all copies to your local Social Security Office]**PRIVACY ACT NOTICE**
ON REVERSE SIDE OF FORM.

1. CLAIMANT

1 Myrtle Johnson

2. WAGE EARNER, IF DIFFERENT

2

3. SOC. SEC. CLAIM NUMBER

3 A4307310

4. SPOUSE'S CLAIM NUMBER

4**5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE.** I disagree with the determination made on my claim because:

- 5**
- The reviewer did not consider my doctor's statement that I met the listing and my illness is degenerative.

An Administrative Law Judge of the Office of Hearings and Appeals will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

6. If you have additional evidence to submit check the following

- 6**
- block and complete the statement:
- ☒

I have additional evidence to submit from

(Name and address of source): Dr. Paul Dogood

455 Medical Way, Baltimore, MD 43407

(Please submit it to the Social Security Office within 10 days.

Attach an additional sheet if you need more space.)

7. Check one of the blocks:

- 7**
- ☒
- I wish to appear at a hearing.

☐ I do not wish to appear and I request that a decision be made based on the evidence in my case.
(Complete Waiver Form HA-4608)

You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security Office will give you a list of legal referral and service organizations. (If you are represented, complete form SSA-1696.)

[You should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 9.]

8.

(CLAIMANT'S SIGNATURE)

8 Myrtle Johnson

ADDRESS

2300 Illard Way

CITY

Baltimore

STATE

MD

ZIP CODE

43202

DATE

1/27/03

AREA CODE AND TELEPHONE NUMBER

555-555-5555

9.

(REPRESENTATIVE'S SIGNATURE/NAME)

9(ADDRESS) ☐ ATTORNEY; ☐ NON ATTORNEY

CITY

STATE

ZIP CODE

DATE

AREA CODE AND TELEPHONE NUMBER

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION-ACKNOWLEDGMENT OF REQUEST FOR HEARING

10.

Request for Hearing RECEIVED for the Social Security Administration on _____ by: _____

(TITLE)

ADDRESS

Servicing FO Code

PC Code

11. Is the request for hearing received within 65 days of the reconsidered determination?

☐ YES ☐ NO

If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security Office.

12. Claimant not represented -

☐ list of legal referral and service organizations provided

13. Interpreter needed -

☐ enter language (including sign language):

14.

Check one:

☐ Initial Entitlement Case☐ Disability Cessation Case☐ Other Postentitlement Case

15.

Check claim type(s):

☐ RSI only	(RSI)
☐ Disability-worker or child only	(DIWC)
☐ Disability-Widow(er) only	(DIWW)
☐ SSI Aged only	(SSIA)
☐ SSI Blind only	(SSIB)
☐ Disability only	(SSID)
☐ SSI Aged/Title II	(SSAC)
☐ SSI Blind/Title II	(SSBC)
☐ SSI Disability/Title II	(SSDC)
☐ HI Entitlement	(HIE)
☐ Other-Specify: (	)

16.

HO COPY SENT TO: _____ HO on _____

☐ CF Attached: ☐ Title II; ☐ Title XVI; or
☐ Title II CF held in FO to establish CAPS ORBIT; or
☐ CF requested: ☐ Title II; ☐ Title XVI
 (Copy of teletype or phone report attached).

17.

CF COPY SENT TO: _____ HO on _____

☐ CF attached: ☐ Title II; ☐ Title XVI
☐ Other attached _____

FORM HA-501-U5 (5-95) EF-FF (10-3-95)

CLAIMS FOLDER

4 Spouse's Claim Number: Enter only if you received SSI.

5 I Request a Hearing Before an Administrative Law Judge ... : State the specific reasons why you feel the decision to terminate your benefits is incorrect. If you need additional space, use a blank sheet of paper and label it "Continuation Sheet."

6 Evidence: If you have new evidence to submit, specify from whom you obtained the evidence. As the form notes, you have ten days from filing this form to submit the new evidence, but it's best if you submit it when you file this form.

7 Check whether you do or do not want to appear at the hearing. Check the appropriate box. If you will not attend the hearing, you need also to complete Form HA-4608, which you can get from your local Social Security office.

If you have a representative and want that person to attend on your behalf (without you), the ALJ will make the decision based on the information in your file and your representative's presentation, unless the ALJ believes your presence is necessary. If you neither have a representative nor want to attend yourself, the ALJ can make a decision based on the written information in your file alone. If you check on this form that you do not want to attend and you file Form HA-4608, you can later change your mind and attend the hearing.

8 Sign and date the form and enter your address and daytime phone number.

9 If a legal representative is handling your appeal (see Chapter 15), that person must sign and complete this form, and must complete and return Form SSA-1696. The SSA cannot discuss your case with your legal representative until it receives Form SSA-1696.

Leave the rest of the form blank. The SSA will complete it.

ii. Form HA-4486: Claimant's Statement When Request for Hearing Is Filed and the Issue Is Disability:

Use this form to update your disability information before your hearing. Here are instructions on how to fill it out. A completed sample follows.

Claimant's Name/Social Security Number: Enter your name and Social Security number or the name and Social Security number of another person on whose behalf this appeal is being filed.

Wage Earner: Enter the name and Social Security number of the person on whose record you received Social Security benefits if you are not the wage earner.

1 Fill in the date you filed your reconsideration. (See Section D1 or D2, above.) This date is on the receipt you received when you filed the reconsideration. If you have worked since you filed your reconsideration and have not previously reported this work information to the SSA, contact your local SSA office. You may have to complete other forms.

2 If your condition has changed since the date you filed your reconsideration, for better or worse, describe how it has changed.

3 If your daily activities or social activities have changed since the date you filed your reconsideration, describe those changes.

4 If you have been examined or treated by a physician as an outpatient since the date you filed your reconsideration, enter the names, addresses, the dates you saw the physicians, the reasons for the visits and the treatments received. Be as complete and precise as possible.

5 If you have been treated in a clinic or hospital since the date you filed your reconsideration, complete the information regarding that visit. If you have a patient number, list it. Again, be as thorough as possible.

6 If you have received treatment from some other medical or vocational service source since the date you filed your reconsideration, enter the name, address and dates you saw the source, the reasons for the visits and the treatments received.

7 If you are taking any medications prescribed since the date you filed your reconsideration, list the names of the medications, the dosages and the name of the physician who prescribed them. This information should be on the prescription bottle.

8 If you began taking any nonprescription medications since the date you filed your reconsideration, list the names of the medications and the dosages taken. If a physician advised you to take these medications, list the physician's name.

9 If you have filed or plan to file for workers' compensation, check "yes." If you have received a workers' compensation award, attach your award letter.

Form HA-4486: Claimant's Statement When Request for Hearing Is Filed and the Issue Is Disability (Page 1)

Form Approved
OMB No. 0960-0316**CLAIMANT'S STATEMENT WHEN REQUEST FOR HEARING IS FILED
AND THE ISSUE IS DISABILITY****Print, type or write clearly and answer all questions to the best of your ability. Complete answers will aid in processing the claim. IF ADDITIONAL SPACE IS NEEDED, ATTACH A SEPARATE STATEMENT TO THIS FORM.**

CLAIMANT'S NAME <u>Maria Chavez</u>	SOCIAL SECURITY NUMBER <u>444-44-4444</u>
WAGE EARNER (Leave blank if name is the same as the claimant's)	SOCIAL SECURITY NUMBER

PRIVACY ACT AND PAPERWORK ACT NOTICE: The Social Security Act (section 205(a), 702, 1631(e)(1)(A) and (B), and 1869(b)(1) and (c), as appropriate) authorized the collection of information on this form. We will use the information on your recent activities, condition, medical treatment, and medications to help us decide if we need to obtain more information. You do not have to give it, but if you do not you may not receive benefits under the Social Security Act. We may give out the information on this form without your written consent if we need to get more information to decide if you are eligible for benefits or if a Federal law requires us to do so. Specifically, we may provide information to another Federal, State, or local government agency which is deciding your eligibility for a government benefit or program; to the President or a Congressman inquiring on your behalf; to an independent party who needs statistical information for a research paper or audit report on a Social Security program; or to the Department of Justice to represent the Federal Government in a court suit related to a program administered by the Social Security Administration.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

TIME IT TAKES TO COMPLETE THIS FORM

We estimate that it will take you about 15 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, or on any other aspect of this form, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001, and to the Office of Management and Budget, Paperwork Reduction Project (0960-0316), Washington, D.C. 20503. Send only comments relating to our estimate or other aspects of this form to the offices listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office whose address is listed in your telephone directory under the Department of Health and Human Services.

- ① 1. Have you worked since 9-14-2001, the date your request for reconsideration was filed? (If yes, describe the nature and extent of work.) → ☐ Yes ☒ No

- ② 2. Has there been any change in your condition since the above date? (If yes, describe the change.) → ☐ Yes ☒ No

- ③ 3. Have your daily activities and/or social functioning changed since the above date? (If yes, describe the changes.) → ☐ Yes ☒ No

- ④ 4a. Have you been treated or examined by a physician (other than as a patient in a hospital) since the above date? (If yes, complete the following.) → ☒ Yes ☐ No

NAME OF PHYSICIAN <u>Dr. Howard Stuckey</u>	ADDRESS (Include ZIP code) <u>225 Piedmont</u> <u>Los Angeles, CA 90023</u>
AREA CODE AND TELEPHONE NUMBER <u>310-555-3333</u>	
HOW OFTEN DO YOU SEE THIS PHYSICIAN <u>every 3 months</u>	DATES YOU SAW THIS PHYSICIAN <u>10-5-2001</u>
REASON FOR VISIT <u>check-ups on osteoporosis and back pain.</u>	

TYPE OF TREATMENT RECEIVED (Include drugs, surgery, tests)

CT scan, Bone density scan, estrogen, pain meds, calcium, Fosamax

Form HA-4486: Claimant's Statement When Request for Hearing Is Filed and the Issue Is Disability (Page 3)**ADDITIONAL SPACE (If needed)**

**I also take Timoptic eyedrops twice a day for glaucoma. As I said on Form HA-501, the DDS did not consider either my osteoporosis or my glaucoma. Furthermore, the opinions of my treating doctors were ignored. My back hurts all the time. My vision is blurry and my side vision is decreasing. Dr. Cole said I may need eye surgery if the various eyedrops that I've tried continue to fail to control my glaucoma. I am slowly going blind and have already lost a lot of my vision.*

I cannot lift 50 pounds as the DDS said I could. I can't see well enough to do the jobs the DDS says I can do.

I want the ALJ to consider my conditions that were not considered by the DDS, which are now even worse than they were at that time. I also want consideration of my treating doctors' opinions.

Lastly, there was no evidence that a DDS doctor ever reviewed my claim other than a signature on a form, which doesn't match the handwriting on the rest of the form (see Residual Functional Capacity form in my file).

iii. Forward Forms to the SSA

Once you have completed all the forms, attach to them copies of any evidence showing that the original determination was incorrect, such as new medical records. Then fold all forms and documents in thirds, insert them in a standard business envelope and mail to your local Social Security office. If you are not sure where that office is, call 800-772-1213. Keep a copy of each form and the originals of your attached evidence for your records. If you can't follow these SSA instructions for mailing, because your documentation won't fit in a standard envelope, then use a larger one.

b. Await SSA Prehearing Case Reviews

After you file your request for an ALJ hearing, the SSA may carry out a prehearing case review if any of the following are true:

- you submit additional evidence
- the SSA determines that additional evidence is available
- Social Security law or regulations change, or
- the SSA finds an error in your file or something else indicating that the prior determination may be changed.

If any of the above occur, the SSA should send your claim back to the DDS or DHO for another evaluation. This will not delay your scheduled ALJ hearing. If your hearing date is approaching and you have not heard from the SSA concerning the prehearing case review, you can agree in writing to delay the hearing until the review ends, but you do not have to.

If the DDS or DHO determines that you should be awarded benefits or your benefits should continue, the SSA will send you a favorable notice and cancel the hearing. If the prehearing review is completely favorable to you—that is, you got everything you wanted—there is no need for a hearing. If any issue was not decided in your favor—such as the date of onset of your benefits—you can request that the hearing take place on that issue only.

The ALJ will also look over your file before the hearing date. Often the ALJ will decide completely in your favor and cancel the hearing. But the ALJ cannot deny your claim by simply reading the file.

Additionally, the ALJ can schedule prehearing conferences with you and/or your representatives to resolve certain issues before the hearing, such as the

time and location of the hearing, the evidence that will be submitted and the witnesses who will appear. The ALJ can have other HA attorneys supervise prehearing conferences and make recommendations to the ALJ—but the ultimate decision rests with the ALJ.

Special Prehearing Review Projects

The SSA is studying a special project in an attempt to decrease the ALJ workload and speed up the claims process. Not all states are involved, in this project, and even if you live in the states involved your case might not be selected for the project. In the project, instead of the ALJ reviewing your case, the review is done by an SSA attorney advisor or a nonattorney adjudication officer. This person has the authority to grant your claim without a hearing, but not to deny your claim. If necessary, the attorney advisor or nonattorney adjudication officer can contact you or your representative for additional medical information or hold informal conferences with you or your representative.

c. Schedule the Hearing

If your case is not resolved in your favor during the prehearing case reviews, the ALJ will notify you or your representative of the time and place of the hearing at least 20 days before it is to take place. The ALJ can be flexible in changing the hearing date, which might be necessary if you or your representative has a conflict. To avoid a conflict, you or your representative can call the ALJ to discuss the hearing date before the ALJ sends out the notice. The ALJ's telephone number should be on all paperwork you receive. You can also easily find any ALJ's telephone number by asking your local Field Office or online at the SSA's Office of Hearings and Appeals at www.ssa.gov/oha/regmap.htm.

d. Where Hearings Are Held

Hearings are held throughout the United States, usually in a federal building in a major city that houses other federal offices—but separate from the DDS and SSA field offices. ALJs sometimes visit other areas in a state to hold hearings. The hearing is usually held as close to your home as possible—most often, within 75

miles. If you must travel more than 75 miles to get to the hearing, the SSA may pay certain costs:

- The SSA may pay your transportation expenses, such as bus fare or gasoline and tolls.
- If you anticipate that you, your representative or necessary witnesses will incur expenses for meals, lodging or taxicabs, you must ask the ALJ to approve the expenses before the hearing.
- If you, your representative or necessary witnesses incur unexpected and unavoidable expenses for meals, lodging or taxicabs, you can ask the ALJ to approve the expenses at the hearing.

You must submit your reimbursement request in writing to the ALJ at the time of the hearing or as soon as possible after the hearing. List what you spent and attach receipts. If you requested a change in the scheduled location of the hearing to a location farther from your residence, the SSA will not pay for any additional travel expenses.

If you need money for travel costs in advance, tell the ALJ as far as possible in advance of the hearing. The SSA can advance payment only if you show that without the money, you cannot travel to or from the hearing. If you receive travel money in advance, you must give the ALJ an itemized list of your actual travel costs and receipts within 20 days after your hearing. If the advance payment was for more than what you spent, the SSA will send you a notice of how much you owe the SSA and you must pay it back within 20 days of receiving the notice.

e. Prepare for the Hearing

It is a good idea to have a representative at an ALJ hearing, unless you are certain you can represent yourself in a legal proceeding. While an ALJ hearing is far less formal than a regular court hearing (see Subsection f, below), it is still a legal proceeding. You can hire a representative after you file your hearing request, if you don't have one already (see Chapter 15).

As explained in Section D3a, above, when you file your request for a hearing you must enclose new evidence you want considered by the ALJ. But between the time of the filing and your hearing, you may obtain new medical evidence. If so, send it to the ALJ as soon as possible.

In addition, think of specific examples of your physical or mental limitations you can give to the ALJ.

By preparing in advance to talk about your impairments and limitations, you not only lessen your anxieties about the hearing, but also increase your chance of convincing the judge of your position.

i. Review Your File

Sections D1c and D2c, above, explain how you can review your file. If you (or your representative) haven't yet done so, before the hearing you'll want to review the following:

- the technical rationales, to understand why the DDS and DHO denied your claim, and
- the reports of medical consultants (MCs), specifically their RFC ratings.

Before you review the MCs' reports, read the relevant chapters in this book discussing various physical and mental impairments (see Chapters 16 through 29). Then look at the reports. Did the MCs make errors? Did they overstate your ability to work? Did they ignore symptoms and limitations for the type of mental disorder you have?

ii. Request Your Record and the Evidence

The SSA will generally give you a free copy of your record, if you say that it is for "program purposes." If your file is quite lengthy, however, the SSA may charge you a fee. Also, you or your representative may request to examine all evidence that is to be part of the hearing record before the hearing, in case you want to object to its admission or offer evidence to challenge it.

iii. Gather Your Medications

Gather together your bottles of medication so you can bring them to the hearing. If you'd rather not bring the medications themselves, make a list of the medications and doses you take.

iv. Figure Out Who All the Witnesses Will Be

If the ALJ plans to ask any expert witnesses to testify, you or your representative will receive a notice before the hearing. The ALJ may have a medical expert (ME) or vocational expert (VE) testify about your medical condition or work abilities. ALJs don't often use MEs; they use VEs more frequently. If you don't receive a witness notice from the ALJ at least a week before the hearing, call the ALJ's office and ask about experts. You should not attempt to personally contact any expert witnesses.

Inform the ALJ about who your witnesses are as soon as possible after you've chosen them. The Field Office can send the ALJ a list of witnesses you want, but neither the ALJ nor the Field Office is responsible for contacting your witnesses and making sure they show up at the hearing. Your witnesses are your responsibility. Don't overload the ALJ with too many witnesses; two or three are best. It is quality, not quantity, that matters here. For example, your treating physician or a caregiver who sees you everyday may know your condition better than anyone. Many claimants have no witnesses.

f. Attend the Hearing

Hearing rooms vary from location to location. Most likely, you'll be in a relatively small room with one or more tables. Remember, this is an informal hearing, not the kind of adversarial proceeding you might have in a court of law—there will be no government representatives arguing against you. If you don't have a lawyer or other representative, you should have received the following type of letter from the SSA:

Social Security Administration

Refer to:
(000-00-0000)

Office of Hearings and Appeals
5107 Leesburg Pike
Falls Church, VA 22041-3255

Addressee _____
Address _____

Dear _____:

We have received your request for hearing. We will notify you in writing of the time and place of the hearing at least twenty (20) days before the date of the hearing. You have indicated that you are not represented.

YOU HAVE THE RIGHT TO BE REPRESENTED BY AN ATTORNEY OR OTHER REPRESENTATIVE OF YOUR CHOICE. A representative can help you obtain evidence and help you and your witnesses, if any, prepare for the hearing. Also, a representative can question witnesses and present statements in support of your claim. If you wish to be represented, you should obtain a representative AS SOON AS POSSIBLE so your representative can begin preparing your case. Please phone us at the number shown above if you decide to obtain a representative.

If there is an attorney or other person whom you wish to act as your representative, you should contact that person promptly to avoid any undue delay in scheduling your hearing. If you are unable to find a representative, we have enclosed a list of organizations which may be able to help you locate one. As indicated on the enclosed list, some private attorneys may be willing to represent you and not charge a fee unless your claim is allowed. Your representative must obtain approval from the Social Security Administration for any fee charged. Also, if you are not able to pay for representation, and you believe you might qualify for free representation, the list contains names of organizations which may be able to help you.

If you have any evidence that you did not previously submit, please send it to this office immediately. If you are unable to send the evidence before the hearing, please bring it with you to the hearing.

You will be able to see all of the evidence in your file at the hearing. If you wish to see it sooner, or have any questions regarding your claim, please call this office at _____. Please have your Social Security number available whenever you call.

Sincerely
Enclosures
(List of Representatives)
(Travel Expense Information)

If you have a representative, sit near that person and have your witnesses sit near you. In addition, follow these tips:

Arrive on time. If you are late, the ALJ may cancel your hearing. If you have a good cause for being late or not showing up—such as a medical emergency or severe weather conditions—the ALJ might reschedule the hearing, but don't count on it. You can lose your claim by not showing up for a hearing. Even if it is rescheduled, it might be several months before you can have another one. If you don't know how to get to the hearing location, check the Office of Hearings and Appeals at www.ssa.gov/oha/regmap.htm. This Internet site has detailed maps and instructions in finding the ALJ's hearing office that you can print out. You can also call the ALJ's office or your local Field Office for directions.

Ask for an interpreter. If English is not your first language and you requested an interpreter on your hearing request form, an interpreter should be at the hearing. If the interpreter is not there, ask that the hearing be rescheduled.

Make sure the hearing is recorded. ALJ hearings are tape recorded. At no charge to you, the proceedings will be transcribed to hard copy if you lose at the hearing and appeal further. The only part of the hearing that might not be recorded is discussion "off the record," but this should only relate to issues that are not relevant to the hearing. In any case, once the hearing goes back on the record, the judge must summarize what took place during the off-the-record discussion.

Don't bring spectators. Your hearing is not open to the general public. Of course, relatives or friends can come with you if you need assistance, but they cannot answer questions for you. If you have any questions about bringing someone, contact the ALJ's hearing office before the hearing.

Be comfortable and be yourself. There's no need to dress up. Also, if you are in pain from sitting too long and need to stand, go ahead.

Be courteous and respectful to the ALJ and everyone else present. Do not curse or use other foul or threatening language, no matter how angry you are.

Pay attention to what is happening. Do not read, eat, chew tobacco or gum or do anything else that might be distracting. If you want to be taken seriously, you

must take the hearing seriously. Also, you cannot answer questions properly if you don't know what's going on. If you have difficulty hearing, wear your hearing aid or let the ALJ know.

Be truthful. When asked questions, don't be vague or evasive. Vague and evasive answers are not clever; they leave a bad impression and force the ALJ to make a decision on factors other than what you say. At the same time, elaborate only to answer the question. Do not exaggerate your pain or other symptoms. Then again, don't be too proud to express how your condition has made your life difficult. If you don't know the answer to a question, just say so.

Don't stage emotional outbursts. ALJs have seen it all before, including crying and other acts of hysteria, and won't be swayed by it if they think it's an act.

On the other hand, if you find yourself in tears as you explain your condition, don't be embarrassed—again, the ALJ has seen it all, and knows that this is the natural response of someone under stress.

g. Follow the Hearing Procedure

ALJs conduct hearings in various ways—no law sets forth a specific sequence for a hearing. This section gives you some idea of what to expect, although the order of your hearing may be very different. If you have a representative, that person may be familiar with the procedures of your ALJ and can fill you in on what to expect.

At the beginning, the ALJ will introduce him- or herself and any witnesses or staff persons. Then, the ALJ may ask if you understand your right to have a representative (if you don't have one). The ALJ will also make a brief statement explaining how the hearing will be conducted, the procedural history of your case and the issues involved. The ALJ will swear you in, that is, ask you to raise your right hand and swear that your testimony shall be "the truth and nothing but the truth." The appropriate response is "I do." Any witnesses will also be sworn to tell the truth before they testify.

As the hearing progresses, the ALJ will need to establish your name, age, address, education and work experience, and some details on your medical history, medications, symptoms, medical disorders and limitations on your activities of daily living. The judge

might ask you questions or have your representative (if any) ask you some questions, and add others of his own. As emphasized earlier, give clear and concise answers, and concrete examples of how your physical or mental impairments limit your ability to function. To say “I can’t do anything” is not informative. Everyone does something during the day, even if it is just sitting on the couch.

i. Your Witnesses

Once the ALJ establishes some basics, he’ll move on to your witnesses, if any. Anyone with some specific knowledge of the limitations imposed by your impairments can be a witness. A few credible witnesses should be sufficient to make the point to the judge; there is little point in having several people repeat the same thing over and over. As discussed in Section D3d, it is important that you review the chapters in this book concerning your impairments. Those chapters will help you understand how witnesses can help your case.

The ALJ will often be the first to question any witnesses you bring to the hearing. You or your representative may also question the witnesses. This means that you or your representative will need to listen carefully during the judge’s questioning, and ask your witness only those questions that will bring to light whatever the judge left out. There’s no need to bore the judge by going over the same territory. However, part of winning your case is making sure that the judge “gets” why you’re disabled. If, for example, the judge asks your doctor about your condition, which is in remission, but fails to ask about the medication that keeps it in remission—and if that medication puts you to sleep—be sure to ask your doctor to talk about it.

Physical disorders. The best witnesses are those who can testify to your inability to perform certain activities because of your impairments.

EXAMPLE: Dwayne has chronic back pain related to degenerative arthritis and scarring around nerve roots associated with prior surgery for a herniated disk. Dwayne describes at his hearing the medications he takes for his pain, the doses, the other pain treatments he receives for the pain, and how the pain limits his sitting, standing, bending, lifting and walking. The DDS said that

Dwayne could lift and carry up to 50 pounds, frequently bend his back and stand six to eight hours daily. Dwayne tells the ALJ that he tried to lift 30 pounds and was in excruciating pain for a week, and that he can’t sit in one position or stand for more than an hour at a time. His wife testifies to these facts as well.

Mental disorders. Your witnesses should be able to testify as to how your mental disorders limit your activities. What can you do and not do? Exercise independent judgment? Plan and cook a meal? Shop alone and return home without getting lost? Remember things, people or obligations? Relate to other people? Bathe and dress alone? Finish tasks in a timely manner, if at all? Do your own grooming and hygiene? Pay bills? An employer or co-worker in a mental disorder claim might testify that you can’t remember work procedures or are too irritable to work with other people.

EXAMPLE: Homer has progressive dementia of the Alzheimer’s type, and his employer is a witness. The employer tells the ALJ that Homer has slowly lost his ability to do his job as a supervisor in a furniture manufacturing facility—he couldn’t remember procedures, didn’t seem motivated any more, and he was irritable and short-tempered with the employees he supervised. As examples, the employer stated that Homer had left dangerous machinery running unattended, didn’t return tools to their proper storage places and blamed other employees for his shortcomings. Sometimes, Homer would just start crying for no reason and that would upset the other employees as well as the work schedule. On other occasions, Homer seemed to be unaware of dangers and walked right in front of a forklift carrying heavy boxes. He tried to give Homer simple jobs requiring minimal skill—such as counting boxes in the warehouse—but Homer still couldn’t seem to do them without too many errors. The manager said he was sorry, but he had to lay Homer off work indefinitely.

Homer’s wife then testifies that he has the same kinds of problems around the house as he had at work. He doesn’t seem interested in anything but

watching TV. His previous hobbies that he loved—fishing and playing his guitar—are no longer of interest to him. He did halfheartedly try to play his guitar once, but angrily broke it against a wall when he couldn't remember even his favorite song. He eats and sleeps poorly, and gets confused doing simple jobs around the house. For instance, he was trying to repair an old chair, and stopped for lunch. When he returned to the chair, he was confused about how to put it together and cried. He can't drive the car, because he gets lost and almost had a wreck by running a red light. The saddest thing of all, Homer almost didn't recognize their daughter who had come to visit from another city. Often, he doesn't remember to change his clothes or bathe unless his wife supervises him.

ii. Medical Experts

Medical Experts (MEs) are doctors in private practice hired by the SSA to help the ALJ understand the medical issues involved in a case. The ME cannot be a doctor who has seen you in the past.

An ALJ can use an ME in several ways: to review your file and give the ALJ a medical opinion before the hearing, and/or to testify at the hearing itself. The ALJ cannot ask the ME for an opinion on vocational matters relating to your claim, even if the ME is also a vocational expert. If an ME will testify at your hearing or review your file, the ALJ must include the ME in the witness list and send you copies of any correspondence between the ALJ and ME.

At the hearing, you can cross-examine any ME involved in your case. Of course, before you can cross-examine the ME, you need to have understood what he or she said. If the ME talks like a medical textbook, the ALJ is supposed to ask follow-up questions that require the ME to explain things in plain English. If the ALJ forgets to do this, be sure to remind him or her. If the ME gave the ALJ advice affecting your claim and is not put on the witness list or brought to the hearing, you have been deprived of your right to cross-examine the ME. This can be the basis of an appeal to the Appeals Council, or later, federal court.

Medical Witnesses: Your Treating Doctor and SSA Medical Consultants

It's highly unusual for a claimant's treating doctor to attend an ALJ hearing. In the event your treating doctor will come, be sure to include the doctor on your witness list. If you don't, the ALJ can postpone the hearing. Even with the testimony of an ME, the ALJ must pay close attention to the opinion of your doctor—even if the ALJ has just the doctor's written opinions in your file. For example, if your treating doctor gave you a lower RFC than the one of the ME (or an MC), the law requires that your treating doctor's opinion have controlling weight, unless it is not supported by substantial evidence. For instance, if the ME says you can lift 50 pounds and walk six to eight hours a day, but your medical doctor wrote that you can lift only 20 pounds and walk six to eight hours a day, then your doctor's opinion should govern. This doctrine is sometimes called the "treating physician rule." It applies with both MEs and VEs (discussed below).

In accordance with federal regulations, the ALJ is supposed to consider the MC's opinion as well. It's important for you to point out that the MC did not examine you, lacks personal knowledge of what you can and cannot do physically and mentally, and is therefore less reliable than your treating doctor. In reality, this may not be true, but this position is supported by the law. The opinions of a consultative examination (CE) doctor cannot be so easily disposed of, given that that doctor did examine you. (See Subsection g, below.) Still, your own doctor's opinion is supposed to have the most weight unless the ALJ has some reasonable basis for rejecting it, such as your doctor's failure to provide evidence to support the opinion.

If you have read this book, then you know far more about SSA medical policies than your average ME. This is an important point, because SSA policies are not the same as medical knowledge. For example, an ME might think that if you have had major epileptic seizures controlled for six months, then you have no environmental restrictions (such as not driving or working at unprotected heights). He or she is entitled to that opinion, but the SSA applies environmental restrictions for epilepsy for a period of 12 months. As this example shows, you and your representative need to be alert to instances where the ME's opinion contradicts SSA policy.

An ME may give a medical opinion as to whether or not you qualify for disability benefits, but such an opinion is not binding on the ALJ. MEs are paid only a small sum of money that is the same whether you win or lose, so they have little financial incentive for bias. Furthermore, MEs are not paid by the SSA to argue against your claim for benefits. In some instances, an ME may argue that your claim should be allowed. In

fact, you can actually request that the ALJ call an ME to testify, if you think it will help your case. Because MEs usually know far less about disability regulations than do MCs, an attorney knowledgeable about Social Security disability often can cross-examine an ME in a way so that the ME agrees to certain facts that point toward your disability. If the ME won't agree to such facts, then it is important to get the ME to admit that she has not examined you.

What the ALJ Might Ask the ME

Below is the Office of Hearings and Appeals' official list of suggested questions for ALJs to use when getting expert testimony from MEs. Studying these questions and the answers given by the ME can help you cross-examine the ME or respond to answers you think are not valid.

1. Please state your full name and address.
2. Is the attached curriculum vitae a correct summary of your professional qualifications?
3. Are you board certified in any medical field and, if so, which field?
4. Are you aware that your responses to these interrogatories are sought from you in the role of an impartial medical expert?
5. Has there been any prior communication between the Administrative Law Judge and you regarding the merits of this case?
6. Have you ever personally examined the claimant?
7. Have you read the medical data pertaining to the claimant which we furnished you?
8. Is there sufficient objective medical evidence of record to allow you to form an opinion of the claimant's medical status? If not, what additional evidence is required?
9. Please list the claimant's physical and/or mental impairments resulting from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. In addition, please state your opinion as to the severity of each impairment, and the exhibits and objective findings which support your opinion.
10. Are there any conflicts in the medical evidence of record which affected your opinion and, if so, please state how you resolved them?
11. Have we furnished you with copies of the pertinent section of the Listing of Impairments, Appendix 1, Subpart P, Social Security Regulations No. 4?
12. In your opinion, do any of the claimant's impairments, when taken individually, meet the requirements of any of the listed impairments? Please fully explain this answer and cite the appropriate sections in the Listing. (Please specifically refer to Listing section.)
13. In your opinion, do any of the claimant's impairments present medical findings which are at least equal in severity and duration to a listed impairment in Appendix 1?
14. In your opinion, if the impairment(s) is a listed impairment or the medical equivalent thereof, on what date did the impairment(s) attain that level of severity?
15. Is there any evidence that the claimant has not properly complied with prescribed treatment?
16. Has any treatment been prescribed which may improve the claimant's condition?
17. List the specific functional (exertional) limitations, such as sitting, walking, standing, lifting, carrying, pushing, pulling, reaching, and handling imposed by these impairments.
18. List the specific functional (nonexertional) limitations, such as environmental restrictions (sensitivity to fumes, etc.), or visual limitations, such as inability to read small print or work with small objects, imposed by these impairments.
19. Please describe the claimant's visual acuity in terms of its effect on the claimant's ability to work safely.
20. Do you have any additional comments or information which may assist us in reaching a decision? If so, please state.

iii. Vocational Experts

Vocational experts (VEs) are people with vocational expertise who evaluate residual functional capacity (RFC) ratings (see Chapter 8) to determine if there are jobs in the national economy you can do. Like medical experts, some VEs are consultants for the SSA's Office of Hearings and Appeals. MEs are specialists in various medical disciplines and have medical licenses; a few MEs are also vocational experts. The training and qualifications of a VE are not standardized; a vocational expert may claim a background in a variety of fields, such as psychology, vocational education, vocational counseling or vocational rehabilitation. Someone could call themselves a vocational expert without even having a college degree, while others have advanced university degrees in subjects such as vocational education. Various credential labels may appear after a vocational expert's name, such as certified vocational evaluator or expert (CVE), certified rehabilitation counselor (CRC), certified case manager (CCM), certified disability management specialist (CDMS), or federally certified rehabilitation counselor for the U.S. Dept. of Labor. So you might see something like this, John Doe, Ph.D., CVE, CRC, CCM. Although the legal standards for being a vocational expert are slim, there has been a private effort to create board certification requirements for being a vocational expert. For example, the American Board of Vocational Experts (www.abve.net), a nonprofit organization, has high standards for certification. (Note that vocational analysts used by a DDS are usually trained by the DDS and may have a much more limited vocational education and background than vocational experts in private practice.)

The ALJ may have a VE at your hearing—and you should have been told this when you received the ALJ's witness list. You should also have been sent copies of any correspondence between the judge and the VE. Since a VE reviews your file and offers an opinion about your job capabilities, the VE is subject to cross-examination just like a medical expert. And, as with an ME, the judge is supposed to make sure that the VE speaks in plain English that you can understand. In addition to questions at the hearing, the ALJ might send a VE interrogatories (questions) about vocational aspects of your claim, before or after the hearing. If the answers are obtained by the ALJ after a hearing, and your claim is denied, you have a right to

examine that evidence and should be informed by the SSA that it exists. The ALJ will ask the VE about the types of jobs you could do, given your impairments.

You or your authorized representative will have the chance to question the VE as well. VEs also refer to the federal government's *Dictionary of Occupational Titles (DOT)*, which describes the physical and mental requirements of various kinds of work. When there is a disagreement between the VE's opinion and the *DOT*, courts have ruled that the *DOT* should be followed. To counter the VE's testimony, you can bring your own vocational expert to the hearing, if you are willing to pay their fees. You can find numerous private vocational experts simply by putting "vocational expert" in your favorite Internet search engine. To get a good idea of the kind of credentials and experience a VE should have, visit the ABVE website above and review their criteria for certification. You can also call a local Field Office and ask if they have a list of local vocational experts in private practice, as well as try your telephone book under "vocational" and "rehabilitation." Another possibility is to call your state vocational rehabilitation center and ask for the names of vocational experts they might know about. If you have an authorized representative, they will know of available private vocational experts.

Medical doctors and psychologists—your own, MCs and MEs—are not usually vocational experts, and their opinion about whether you can do any job in the national economy carries little weight. For instance, an orthopedic surgeon might have a believable opinion that you can't lift over 20 pounds if he provides the evidence to justify that opinion. But treating doctors then frequently go on to say that claimants are "totally and permanently disabled" or "unable to work." Unless the doctor is also a vocational expert, he is not qualified to say a claimant can't perform any kind of job. Still, your treating doctor's opinion will be an important medical factor. Remember that your treating doctor's opinion about what you can do medically (lifting, walking, etc.) must be accepted when in conflict with an MC's or ME's, provided that this assessment is supported by the evidence. If the VE did not use your treating doctor's medical assessment, find out why. Ask what job recommendations she'd make if she did use his assessment.

What the ALJ Might Ask the VE

Below is the official list of suggested questions for ALJs to use when questioning a vocational expert. Use this to help prepare your own questions for the VE.

1. Please state your full name and address.
2. Is the attached curriculum vitae a correct summary of your professional qualifications?
3. Are you aware that your responses to these interrogatories are sought from you in the role of an impartial vocational expert?
4. Has there been any prior communication between the Administrative Law Judge and you regarding the merits of this case?
5. Has there been any prior professional contact between you and the claimant?
6. Have you read the evidence pertaining to the claimant which we furnished you?
7. Is there sufficient objective evidence of record to allow you to form an opinion of the claimant's vocational status? If not, what additional evidence is required?
8. Please state the following:
9. Claimant's age, in terms of the applicable age category described in sections 404.1563 and 416.963 of federal regulations. (See Chapters 8 and 9.)
10. Claimant's education, in terms of the applicable education category described in sections 404.1564 and 416.964 of federal regulations. (See Chapters 8 and 9.)
11. Claimant's past relevant work (PRW); i.e., the claimant's work experience during the last 15 years, in terms of the physical exertion and skill requirements described in sections 404.1567, 404.1568, 416.967 and 416.968 of federal regulations, and the *Dictionary of Occupational Titles*. (See Chapters 8 and 9.)
12. The extent that any job during the last 15 years required lifting, carrying, pushing, pulling, sitting, standing, walking, climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, feeling, talking, hearing and seeing, as well as any environmental or similar aspects of the job (indoors, outdoors, extremes of heat or cold, wetness, noise, vibration and exposure to fumes, odors or toxic conditions). (See Chapters 8 and 9.)
13. If the claimant's PRW was either at a skilled or semiskilled level, describe the skills acquired by the claimant during the performance of the job(s), and furnish a complete explanation for your opinion(s).
14. Hypothetical Questions:
 - a. Assume that I find the claimant's testimony credible, that because of his impairment he can only sit for up to three hours, stand and/or walk for no more than three hours before experiencing severe pain, and lift no more than ten pounds, and that he must lie down for at least two hours in any eight-hour period to relieve the pain. If I accept this description of his limitations, could the claimant, considering his age, education and his work experience, engage in his past relevant work? Or, if not, could he transfer acquired skills to the performance of other skilled or semiskilled work?
 - b. Assume that I find that the claimant can sit for up to three hours at a time, stand and/or walk for no more than three hours, and lift up to ten pounds. Can he engage in his past work? If not, can he transfer any skills to perform other skilled or semiskilled work?
 - c. Assume that I find that the claimant can stand and walk for approximately six hours, and lift no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to ten pounds. Can he engage in his past work or, if not, can he transfer his skills to perform other skilled or semiskilled work?
 - d. If the claimant can transfer his skills to perform other skilled or semiskilled work, please provide some examples of these jobs and the frequency with which they are found in the national economy.

iv. Consultative Examinations

If the ALJ needs medical information to evaluate limitations you raise that are not covered in your medical records, he may have you undergo a consultative examination (CE) by a physician or psychologist who does work for the SSA (see Chapter 2, Section C2). The ALJ could request that you attend a CE before the hearing, or could decide on the need for more information during a hearing itself. In the latter instance, the ALJ would postpone the hearing until after the CE.

h. Await the ALJ's Decision

Don't expect the ALJ to give you a decision at the end of the hearing. The SSA will send you a copy of the ALJ's decision, which usually takes about two more months. If your claim is denied by the ALJ, you can appeal further to the Appeals Council.



Not all hearings end the day they begin. Various circumstances might cause you or the ALJ to suggest that the hearing be continued to another day. For example, the ALJ could decide that additional evidence is needed before making a decision on your case. You may have to gather and submit this evidence yourself, or the ALJ may order additional tests or opinions. If the ALJ gathers the additional evidence, you will be given an opportunity to look it over and request a supplemental hearing if you think you need one.

4. Review by the Appeals Council

The final step in your administrative appeals process is with the SSA's Appeals Council (AC).

Even if you don't appeal to the AC, the AC can select ALJ decisions for review at random or if referred from other divisions of the SSA. This means that on its own, the AC could review and grant a claim that had been denied by an ALJ, but it also means that the AC could reverse an ALJ allowance of benefits and deny your claim. When the AC decides to review a case on its own, you will be notified of its proposed action (reversing or affirming) and given an opportunity to offer input. Although it is very unlikely that your case would fall into such a review sample, it does happen.

a. How to Appeal to the Appeals Council

To appeal to the AC, you must complete and return to the SSA Form HA-520-U5: Request for Review of Decision/Order of Administrative Law Judge. The SSA must receive this form within 60 days of when you receive your denial notice from the ALJ, or 65 days from the date on the ALJ's denial (five days are allowed for mailing).



You must use forms provided by the SSA. You can obtain them at your local SSA Field Office or by calling the SSA hotline at 800-772-1213, Monday through Friday (except holidays), from 7 a.m. to 7 p.m. If you are deaf or hard of hearing, TTY service representatives are available at the same times at 800-325-0778. You can also download many necessary forms from the Social Security Administration website at www.ssa.gov. The form is not available from the DDS.



If you appeal to the Appeals Council, your benefits can continue. However, read the sidebar at Section D2a above.

Your other option is to simply write a letter, but it's best to use the official form so you include all necessary information. If you decide to just write a letter, state: "I request that the Appeals Council review the Administrative Law Judge's action on my claim because [state a reason, such as one of the following]:"

- My ALJ hearing only lasted 20 minutes and I didn't have a chance to present my evidence.
- I think the ALJ made a mistake in not considering my treating doctor's opinion.
- I have new evidence showing that the ALJ was wrong in denying my claim.
- The ALJ did not consider my mental problems.

Once you have completed the form, attach to it copies of any evidence showing that the ALJ's decision was incorrect, such as, for example, new evidence showing your heart disease is more severe than thought by the ALJ. Then fold the documents in thirds, insert them in a standard business envelope and mail them to your local Social Security Field Office. The Field Office will then mail your appeal papers to the Appeals Council, Office of Hearings and Appeals, 5107 Leesburg Pike, Falls Church, VA 22041-3255. Keep a

copy of your completed form and the originals of your attached evidence for your records. You may need a larger envelope, if you have too many documents to follow the SSA's instructions about using a standard business envelope.

b. Will the Appeals Council Review Your Case?

The AC will examine your review request and notify you in writing of its intended action. It may grant, deny or dismiss your request for review. The AC is not a place where you are likely to find success. If you file late, request a dismissal or die, the AC may dismiss your claim without reviewing it. Even if none of these occur, the AC can dismiss your case without review unless it finds any of the following:

- an abuse of discretion by the ALJ or an error of law (an abuse of discretion might be something like the ALJ deciding that ten minutes is enough for a hearing; an error of law would apply to something like not permitting a claimant or their authorized representative to cross-examine a witness, or not considering the opinion of the treating doctor)
- the ALJ decision is not supported by substantial evidence, or
- a broad policy or procedural issue raised by the case (such as the ALJ not notifying a claimant that an expert witness would be present at the hearing).

The AC usually looks for a flaw in the ALJ decision before granting a review. In those situations, your chance of winning is only 2%–3%. For most people, the only reason to file a request with the AC is to exhaust all the SSA administrative appeal avenues, which you must do before you sue the SSA in court. (See Section D5, below.)

c. How the Appeals Council Conducts a Review

The AC judge will attempt to process your review request at the AC level. If the AC feels the claim needs further factual development before it can issue a legally sufficient decision, it will return the case to the ALJ to gather the evidence, which provides the opportunity for you to have another hearing and for the ALJ to issue a new decision.

If the AC keeps your case for review, it will look at the evidence of record (the evidence that was in your file when you asked for AC review), any additional evidence submitted by you, and the ALJ's findings and conclusions. Also, the AC can consult physicians (called Medical Support Staff or MSS) and vocational experts on its staff. When the MSS recommends granting your claim and the AC relies on that recommendation to reach its decision, the AC must add the MSS comments to your record.

If the MSS recommendation is unfavorable and the AC intends to rely on that recommendation to make its decision, the AC must offer the MSS report to you for comment before entering it into the record. If the AC doesn't use the MSS opinion to reach a decision, the AC does not make the MSS analysis a part of your record. The AC uses its MSS in only about 17% of its decisions—but must use the MSS if it grants you benefits based on the fact that your impairments equal a listing. (See Chapter 7 for an explanation of listings.)

d. The Appeals Council's Decision

If the AC dismisses your case without review, it will send you a notice advising that it finds no basis to disturb the ALJ's decision. The ALJ's decision then becomes the final decision. This is usually the result of an AC review.

If the AC does review your case, remember that you aren't likely to win, and you'll be lucky to hear from the AC within a year. It is possible to file another initial disability claim while your file languishes at the AC, but the SSA can delay your new claim until the AC makes its decision.

5. Sue the SSA in Federal Court

If you disagree with the AC's decision or the AC refuses to review your case, you can pursue your case further by filing a lawsuit—that is, suing the SSA—in U.S. district court. You must file your complaint in a district court within 60 days after you receive notice of the AC's dismissal or 65 days from the date on the AC's decision. If you don't yet have an attorney representative, you will almost certainly need one now.

Federal judges hear disability cases without juries. The judge is only supposed to review the case for legal errors by the SSA, but in reality many judges rule on factual questions, too, substituting their judgment for that of the SSA. Of course, federal judges are not doctors. Nor do they have the training to interpret medical information, so they often base their decision on which doctor they believe. They most often believe treating doctors, and may rely on the opinion of their clerks—attorneys working under their supervision in their office. District court judges reverse ALJs or the AC in at least a third of all cases, often saying that the SSA did not give sufficient weight to a treating doctor's opinion, did not consider pain and other symptoms or should have asked for assessments of abilities from treating doctors.

Since the AC refuses to review most claims, most federal court reversals are of an ALJ's decision rather than the AC. The federal judge may simply allow your claim or uphold the SSA's denial determination—but these aren't the court's only options. In addition, the court may send your claim back to the ALJ to re-evaluate your claim according to some special legal instruction. For example, the court may find that the ALJ did not obtain important medical information or consider your treating doctor's opinion. The court may order the ALJ to do these things at the new hearing.

Although you have a fair chance of winning an appeal in federal court, it is not an attractive option. Fewer than 1% of disability claimants actually take their cases to court. Suing the SSA is expensive and very time-consuming. Even if you win, it might take years to reach that level. Consequently, few attorneys are willing to file a disability case in federal court. Of course, you could represent yourself, but few non-attorneys have the skills, time or money to do so, especially if they suffer from severe medical conditions.



Should you choose to appeal on your own, you can refer to [Represent Yourself in Court: How to Prepare & Try a Winning Case](#), by Paul Bergman & Sara Berman-Barrett (Nolo), for guidance.

If you do file in federal court, you can file a new initial claim at the DDS while your case is pending, and the SSA will let the new claim proceed as long as your alleged onset date is after the date of the last administrative action (AC denial or dismissal) taken on the claim pending in federal court.

Inconsistency of Federal Court Decisions

The U.S. federal court system is divided into circuits. Each circuit covers several states—for example, the 8th Circuit contains North Dakota, South Dakota, Nebraska, Minnesota, Iowa, Missouri and Arkansas. If you lose a case in a federal district court, you can appeal to a circuit court of appeals. The decision of an individual circuit court is binding only on the district courts within its circuit. For instance, a decision by 8th Circuit Court of Appeals will not have to be followed in New York, and a decision by the 2nd Circuit Court of Appeals (which covers New York) isn't binding on federal district courts in Nebraska. This means that the outcome of your case could depend on where you live.

If you lose an appeal to a federal circuit court, you can theoretically take your case to the U.S. Supreme Court, but the Supreme Court only hears cases which it thinks warrant its special consideration. If your claim involves a broad legal or Constitutional issue that potentially affects the entire country, the Supreme Court might consider hearing your case.

E. Reopening of Decisions

An alternative to appealing your case is requesting a reopening of your claim—asking for a second look by whichever administrative level of the SSA has your claim.

You can ask for a reopening in the following situations:

- If you make your request within 12 months of the date of the notice of the initial determination by the DDS, ALJ or AC, you can ask for a reopening for any reason.

- If you believe that the determination to deny you or terminate your benefits was based on fraud or similar fault, you can request a reopening at any time.
- If you make your request within four years for SSDI applicants or two years for SSI applicants of the date of the notice of the initial determination, the SSA may reopen the case if it finds good cause. Good cause is defined as follows:
 1. new, important (called “material”) evidence
 2. a clerical error in the computation of your benefits, or
 3. evidence of a clear error.

Good cause does not include a change of legal interpretation or administrative ruling upon which the determination or decision was made.

If the SSA agrees to reopen your case and issues a revised determination, that new determination is binding unless one of the following is true:

- you file a request for reconsideration or a hearing
- you file a request for review by the AC
- the AC reviews the revised decision, or
- the revised determination is further revised.

F. Refiling an Initial Claim

If you lose your appeal (no matter at what level), you have the option to file another initial claim. Just go to your local Social Security Field Office and start the process over again. Your chance of being granted benefits will improve if a change in your condition—such as a worsening of impairments or new impairments—warrants a different disability decision.

A possible legal barrier to filing a subsequent claim is called *res judicata*, which means “the thing has been adjudicated.” The DDS can use *res judicata* to avoid deciding a claim that has previously been determined if all the facts, issues, conditions and evidence are the same facts.

If you file a new disability application with the same issues and no new facts or evidence, your application may be denied on the basis of *res judicata*. The SSA may give you the benefit of the doubt and treat your new claim as a request for reopening (see Section E, above).

If anything has changed—including the law or regulations—*res judicata* won’t apply. Also, if you are still insured for disability (in other words, still eligible for benefits based on your work earnings) after the date of your last determination, *res judicata* cannot be applied to the time after that determination. This is true even if you allege the same onset date, same impairment and same condition.

EXAMPLE—RES JUDICATA APPLIES: You are denied on your first application and do not appeal. You file a second application, allege the same onset date, submit no new evidence and show that you were last insured for benefits before the date of your last determination. The SSA denies your claim on the basis of *res judicata*.

EXAMPLE—RES JUDICATA DOES NOT APPLY: The same example, except that you submit new evidence with your claim. The new evidence could describe more about how your condition has been all along, or show a new development in your illness. The SSA would not apply *res judicata* to your claim. ■

Chapter 13

Once You Are Approved

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A. Disability Benefit Payments

Once you are awarded benefits, you will receive a Certificate of Award containing answers to many questions about Social Security payments. If any of your relatives are eligible for benefits, they will receive a separate notice and a booklet about what they need to know.

1. When Benefits Start

You will only be paid SSDI benefits for the five months prior to the time you are declared disabled. Your first payment may include some back benefits. SSI benefits begin the month following the month in which you qualify for disability benefits. (See Chapter 10 for more details.)

2. How Much Benefits Will Be

How much your benefits will be depends first on whether you have an SSDI claim or an SSI claim, because each program uses different formulas to determine benefits. SSDI benefits are higher than SSI benefits.

a. SSDI Benefits

The SSA will tell you the amount of your benefits when it sends you notice that your claim has been allowed. Your SSDI benefits are calculated using a complicated formula. First, the SSA calculates your average earnings over a period of many years, known as the average indexed monthly earnings (AIME).

Your AIME is then used to calculate your primary insurance amount (PIA)—the basic figure the SSA uses in finding the actual benefit amount. The PIA is fixed percentages of predetermined dollar amounts of your AIME. The dollar amount increases yearly, but the percentages stay the same. For 2003, for example, the monthly PIA benefit for a disabled worker is as follows:

Percentage	Amount of AIME
90%	0–\$606
32%	\$606–\$3,653
15%	\$3,653

EXAMPLE: Horace's AIME is \$5,500. The SSA calculates his PIA as follows:

$$\begin{array}{rclcl}
 \$606 & \times & 90\% & = & \$545.40 \\
 \\
 \text{Plus } & \$3,653 & & & \\
 & \underline{-\$606} & & & \\
 & \$3,047 & \times & 32\% & = & 975.04 \\
 \\
 \text{Plus } & \$5,500 & & & & \\
 & \underline{-\$3,653} & & & & \\
 & \$1,847 & \times & 15\% & = & \underline{\$277.05} \\
 \\
 \text{Total} & & & & = & \underline{\$1,797.50}^*
 \end{array}$$

* rounded to nearest \$ 0.10 as required

The maximum family benefit (MFB) is the total monthly benefit that can be paid to you (the wage earner) and any family members entitled to benefits on your record. The MFB does not affect the amount of your benefit. Instead, added to your PIA are different amounts for each family member based on a percentage of your PIA. For example, a child eligible to receive benefits on your record while you are alive is entitled to 50% of your PIA; if you die, the percentage increases to 75% of your PIA. These amounts will be reduced if the total exceeds the MFB limit, which is 85% of the AIME, as long as the amount doesn't fall below your PIA. At the same time, the total amount cannot exceed 150% of your PIA. The dollar amounts increase yearly, but the percentages stay the same. For 2003, for example, the MFB benefit for a disabled worker was as follows:

150% of the first \$774 of PIA, plus
 272% of PIA over \$774 through \$1,118, plus
 134% of PIA over \$1,118 through \$1,458, plus
 175% of PIA over \$1,458.

This basic summary doesn't consider the many factors that can influence the actual amount. It is not practical for you to try to calculate your own monthly benefit. It makes more sense to let the SSA do the calculations. Of course, the SSA could make a mistake.

If you want to double-check the SSA's figure, you can download a program from the SSA's website (www.ssa.gov/retire/calculators.htm) to calculate your PIA and MFB. The SSA's official calculations supersede the answers you get from the program, but it is fairly accurate and could be used to check the SSA's numbers. (Also, see Chapter 2 regarding how your benefit can be reduced by earnings, workers' compensation and other public disability or pension payments.)

The following table can give you an idea of the approximate monthly amount of SSDI benefits paid to disabled recipients and qualified family members. Be aware that these amounts can vary with individual eligibility circumstances.

Type of Beneficiary	Award
Disabled workers	\$878
Spouses	\$431
Children	\$539
Disabled widows and widowers	\$523

b. SSI Benefits

While your entitlement to SSI depends on both your income and resources, only your income influences the amount of your monthly payment. In 2003, the maximum SSI payment for a disabled adult is \$552 per month and \$829 for a couple. Some states supplement SSI payments with more money.

Your SSI check might not be the same every month. Each monthly amount depends on your other income and living arrangements. The SSA will tell you whenever it plans to change the amount of your check. (See Chapter 1 for information on how your income and resources affect the amount of your SSI benefits.)

3. When and How Payments Are Made

When and how benefits are paid depends on the type of benefit, and whether the payment is by check or direct deposit to a bank account. If you don't have a bank account, your local SSA Field Office can help you find banks that offer low- or no-cost accounts to receive your SSDI or SSI benefits.

a. Check by Mail

SSI checks and combined SSI/SSDI checks should arrive on the first day of the month. If the first falls on a weekend or legal holiday, you should receive your check on the business day before. For example, if your payment date would fall on a Sunday, you should receive your check on the prior Friday instead.

SSDI recipients who started receiving benefits before 1997 get their checks on the third day of the month or the business day preceding it, if the third is a weekend or holiday. If you were awarded benefits after 1997, your SSDI check will arrive on a day as dictated by your birthday:

Day of Month	Day SSDI Arrives
1st – 10th	Second Wednesday
11th – 20th	Third Wednesday
21st – 31st	Fourth Wednesday

The SSA's site (www.ssa.gov) has a colorful calendar showing the exact dates you will receive your payments if you live in the United States.

If your check is ever delayed, wait at least three days before reporting it to the SSA. If you lose your check after you receive it, contact the SSA immediately. The SSA can replace the check, but it takes time. Cash or deposit your check as soon as possible after you receive it. If you don't cash or deposit it within 12 months of the date it was issued, the check will be void.

If you are living outside the United States, your checks may arrive later than the due date. Delivery time varies from country to country and your check may not arrive the same day each month. If you are in the United States now and plan to be out of the country for less than three months, you may want your payments to stay in the United States. Any Social Security office can help you arrange this.

b. Direct Deposits

The SSA prefers that you have a bank (or savings and loan association or credit union) account so that your check can be deposited directly, but this is not a requirement. Direct deposits follow the same date

rules as for checks. If your deposit doesn't take place on the date scheduled, call the SSA at once so they can put a trace on the payment. The deposit should always be in your account on the correct date.

If you have a bank account, the SSA will generally insist on direct deposit. The SSA allows for exceptions (see sidebar "When the SSA Doesn't Require Direct Deposit," below); even so, direct deposit has important advantages over mailed checks.

Direct deposit is safe:

- It avoids the possibility of lost, stolen or forged checks.
- If you travel, you do not have to make special arrangements for someone to safeguard your checks. The money will be waiting for you in your account.
- Because it is electronic and processed by computers, direct deposit offers a greater degree of financial privacy than checks.

Direct deposit is reliable:

- There is no chance of your check being lost in the mail or stolen from your mailbox.
- Direct deposit payments are traceable through the banking system. The rare problem can usually be quickly resolved.
- Your bank statements record the payment amount received each month. You can also contact your financial institution to verify the deposit each month.

Direct deposit is economical:

- Lines at banks are usually long on check day; if you delay going to your bank to avoid the crowds, you will not have immediate use of your money.
- Banks must make funds available at the opening of business on the payment date. If you use direct deposit with an interest-bearing account, you can earn maximum interest on your money.
- If you are mailed checks and don't have a bank account, you can incur check-cashing fees.
- Many banks offer free services to direct deposit customers.

Direct deposit is convenient:

- You don't have to make a special trip to a bank and wait in line to cash or deposit the check—this is especially important in bad weather or times of illness.

- Problems associated with cashing checks, such as proving identity, are eliminated.
- You do not have to wait for the mail to make sure your check is safely received.
- You avoid mail delays and receive your payment faster than if you are paid by check.
- When direct deposit payments are made to foreign banks, you avoid check cashing and currency conversion fees.

c. Overpayments (Erroneous Payments)

If you receive a check or direct deposit payment to which you are not entitled—for example, for your spouse who died before the date the check was issued—you must return it to the SSA. If you return the check by mail, enclose a note telling why you are sending the payment back.

4. Paying Taxes on Disability Benefits

Social Security recipients must pay taxes on their benefits if they have substantial additional income. If you file an individual tax return and your combined income—your adjusted gross income plus nontaxable interest plus one-half of your Social Security benefits—is between \$25,000 and \$34,000, you may owe taxes on 50% of your Social Security benefits. If your combined income is above \$34,000, up to 85% of your Social Security benefits is subject to income tax.

If you file a joint return, you may owe taxes on 50% of your benefits if you and your spouse have a combined income between \$32,000 and \$44,000. If your combined income is more than \$44,000, up to 85% of your Social Security benefits is subject to income tax.

Most claimants don't make enough money to worry about paying taxes on their disability benefits. But situations vary; if you have substantial additional income, consult a knowledgeable tax preparer. SSI recipients are particularly unlikely to have a tax problem, since if they are liable for taxes they probably make too much to get SSI.

When the SSA Doesn't Require Direct Deposit

As stated above, direct deposit is required only if you have a bank account into which the SSA can deposit your benefit checks. Even then, certain accounts are excluded from SSA direct deposit requirements:

- savings accounts containing only funds set aside for burial or funeral expenses
- accounts held by SSI recipients for Plan for Achieving Self-Support (PASS) money (PASS is discussed in Section D2)
- accounts you hold in foreign financial institutions when you reside in the United States
- accounts you hold in foreign financial institutions when you reside in countries in which SSA's International Direct Deposit (IDD) is not yet available (see Section B5, below)
- accounts held at investment firms, even if you have check-writing privileges on them
- any account that prohibits withdrawals until a specified time of the year, such as "Christmas Club" accounts, which can't be tapped into until the holiday season
- accounts subject to attachment, levy, garnishment or other imposition established by court order or other legal proceeding
- trust accounts in which you are the trustee on behalf of another person
- trust accounts held by a third party on your behalf
- savings accounts established under the Welfare Reform Reconciliation Act of 1996 to maintain retroactive SSI benefits for disabled or blind children, and
- U.S. dollar accounts you hold in foreign financial institutions.

You do not have to give the SSA any documentation to exclude an account from the direct deposit requirements. Your description of the account is enough. If your only bank account is an excluded account, the SSA will have you sign a statement to waive the requirement for direct deposit and you will receive a check instead.

It is possible for you to request direct deposit to some of the above excluded accounts. However, payments cannot be sent to accounts held in foreign financial institutions if you reside in the United States. Also, SSI payments cannot be sent to foreign banks by direct deposit.

5. How Long Payments Continue

Your disability benefits generally continue as long as your impairment has not improved and you cannot work. Because of advances in medical science and rehabilitation techniques, increasing numbers of people with disabilities recover from serious accidents and illnesses. Some people recover enough to return to work. Your case will be reviewed periodically to make sure you're still disabled (see Chapter 14).

Your benefits may be reduced or terminated if you marry, receive certain other disability benefits or move to certain countries where payments are prohibited (see Section B5, below). Also, if you are receiving SSDI when you turn 65, your benefits automatically will be changed to retirement benefits, generally for the same amount. If you are receiving benefits as a disabled widow or widower when you turn 60, your benefits will be changed to regular widow or widower benefits.



For a broad discussion of Social Security issues see *Social Security, Medicare & Government Pensions: Get the Most Out of Your Retirement & Medical Benefits*, by Attorney Joseph Matthews & Dorothy Matthews Berman (Nolo).

6. Eligibility for Medicare and Medicaid

Medicare is a health insurance program for eligible people who are age 65 or over or disabled. Medicare protection includes hospital insurance and medical insurance. The hospital insurance part of Medicare pays hospital bills and certain follow-up care after you leave the hospital. Medical insurance helps pay doctor bills and other medical services.

Medicare coverage does not start right away for SSDI recipients. Instead, you become eligible after you receive SSDI benefits for 24 months. If you have chronic kidney disease requiring regular dialysis, amyotrophic lateral sclerosis or a transplant, however, you may qualify for Medicare almost immediately. SSI recipients have no Medicaid waiting period.

There is no cost for the hospital insurance. If you want the medical insurance, you must enroll and pay a monthly premium by having it withheld from your payment. If you choose not to enroll when first eligible

and then sign up later, your premiums will be 10% more for each 12-month period you could have been enrolled but were not. If you receive Medicare and have low income and few resources, your state may pay your Medicare premiums and, in some cases, other out-of-pocket Medicare expenses such as deductibles and coinsurance. Contact a local welfare office or Medicaid agency to see if you qualify.

Once you are covered by Medicare's medical insurance, if you want to cancel it, notify the SSA. Medical insurance and premiums will continue for one more month after the month you notify the SSA that you wish to cancel. For example, since Medicare generally does not cover health services you get outside the United States, you might want to either not sign up for coverage or cancel coverage if you plan to be abroad for a long period of time. There is little reason to pay the premium until you return.

B. Reporting Changes—SSDI Recipients

Promptly report to the SSA any changes that may affect your or your family members' SSDI benefits. To let the SSA know the new information, you can call 800-772-1213 (voice) or 800-325-0778 (TTY), visit any SSA office (a clerk will help you) or complete and mail in the reporting form you received when you applied for benefits.

If you send a report by mail, be sure to include the following:

- your name or the name of the person on whose account you get benefits
- your Social Security number or the Social Security number of the person on whose account you get benefits
- name of the person about whom the report is being made, if not you
- nature of the change
- date of the change, and
- your signature, address and phone number, and the date.

If you don't report a change, you might miss out on money to which you are entitled or have to pay back money to which you were not entitled. In extreme situations—for instance, if you lie to the SSA to keep getting benefits—you could be prosecuted for Social

Security fraud and fined, imprisoned or both. The SSA has ways of finding out about true income and other factors affecting your eligibility for certain kinds of benefits—such as obtaining information from your employers and the Internal Revenue Service. Even if the SSA has no way to force you to repay an overpayment right now, the SSA will wait and deduct it from your retirement benefits when you turn 65.

The events that must be reported follow.

1. You Move

As soon as you know your new address and phone number—even if it's before you move—let the SSA know. Include the names of any family members who also should receive their Social Security information at the new address.

Even if your benefits are deposited directly, the SSA must have your correct address to send you letters and other important information. Your benefits will end if the SSA is unable to contact you.

2. You Change or Establish Bank Accounts

If you receive your check by direct deposit and change banks—that is, close one account and open another—you must report that to the SSA so your direct deposits continue. If you've been receiving your checks directly and open a bank account, let the SSA know so it can set up direct deposit.

3. Your Condition Changes

If your medical condition improves or you believe you can work, you are responsible for promptly notifying the SSA. Failure to do so could mean that you would get payments you aren't entitled to receive—and might have to repay the SSA.

4. You Go to Work

Notify the SSA if you take a job or become self-employed, no matter how little you earn. If you are

still disabled, you will be eligible for a trial work period and can continue receiving benefits for up to nine months (see Section D, below).

If you return to work and incur any special expenses because of your disability, such as specialized equipment, a wheelchair or some prescription drugs, let the SSA know. In some cases, the SSA will pay your expenses.

5. You Leave the U.S.

If you move abroad, the reporting requirements are the same as for other types of reportable changes as described in the introduction to this section.

If you leave the United States and have questions about your SSDI while you are out of the country, you have several places to turn to get assistance:

- SSA Federal Benefits Units at U.S. consulates and embassies or at the American Institute in Taiwan
- SSA representatives stationed at consulates and embassies in London, Athens, Rome, Mexico City, Guadalajara, Manila and Frankfurt, or
- SSA Field Offices located in the British Virgin Islands, Canada and Western Samoa.

a. Your Right to Payments When You Are Outside the U.S.

Thousands of SSDI beneficiaries and others on their work record receive disability benefits while residing outside of the United States. If you are not in one of the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, you are considered to be outside the United States. If you are a U.S. citizen and receive SSDI, you can continue to receive payments outside of the United States, as long as you are eligible for them, without having to return to the United States periodically. You do not have to notify the SSA for temporary trips outside of the U.S., regardless of the length. But you must be able to receive mail from the SSA. If no one will keep track of your U.S. mail and you will be outside of the U.S. for more than one or two months, give your local Social Security Field Office an overseas address. If you move permanently to another country,

definitely tell the SSA, as you are required to keep the SSA informed of your residence address.

Much more complicated rules apply to aliens receiving benefits. If you are outside the United States for at least 30 days in a row, you are considered outside the country until you return and stay in the United States for at least 30 days in a row. In addition, if you are not a U.S. citizen you may be required to establish lawful presence in the United States for that 30-day period before you can receive disability benefits. "Lawful presence" means you are in the United States legally. (More specific requirements for lawful presence are given in Chapter 1, Section A1.) Because of the large numbers of international treaties and agreements, there are different rules for receiving benefits in different countries. With some exceptions, an alien beneficiary who leaves the United States must either return to the United States at least every 30 days, or for 30 consecutive days during each six-month period, in order to continue to draw benefits.

Once your payments stop, they cannot be started again until you come back and stay in the United States for an entire calendar month. This means you have to be in the United States on the first minute of the first day of a month and stay through the last minute of the last day of that month. For example, If you move back on July 2, you won't be eligible again for SSDI until September 1, after you have been in the United States the full month of August. In addition, you may be required to establish lawful presence in the United States for that full calendar month period. The SSA will not give you back payments for the months you missed.

b. Additional Residency Requirements for Dependents and Survivors

If you receive benefits as a dependent or survivor of a worker, special requirements may affect your right to receive SSDI payments while you are outside the United States. If you are not a U.S. citizen, you must have lived in the United States for at least five years, during which time the family relationship on which benefits are based must have existed. For example, if you are receiving benefits as a spouse, you must have been married to the worker and living in the United States for at least five years.

Benefits When Living Abroad

Category 1

If you are a citizen of one of the following countries, payments will continue no matter how long you are outside the United States, as long as you remain eligible.

Austria	Ireland	Portugal
Belgium	Israel	South Korea
Canada	Italy	Spain
Finland	Japan	Sweden
France	Luxembourg	Switzerland
Germany	Netherlands	United Kingdom
Greece	Norway	

Category 2

If you are a citizen of one of the following countries, payments will continue no matter how long you are outside the United States, as long as you remain eligible, unless you receive payments as a dependent or survivor.

Albania	Dominican Republic	Monaco
Antigua and Barbuda	Ecuador	Nicaragua
Argentina	El Salvador	Palau
Bahamas	Gabon	Panama
Barbados	Grenada	Peru
Belize	Guatemala	Philippines
Bolivia	Hungary	Poland
Bosnia-Herzegovina	Guyana	St. Kitts and Nevis
Brazil	Iceland	St. Lucia
Burkina Faso	Ivory Coast	San Marino
Burkina Faso	Jamaica	Slovak Republic
Colombia	Jordan	Slovenia
Costa Rica	Latvia	Trinidad-Tobago
Croatia	Liechtenstein	Turkey
Cyprus	Macedonia	Uruguay
Czech Republic	Malta	Venezuela
Denmark	Marshall Islands	Yugoslavia, Fed. Rep. of
Dominica	Mexico	
	Micronesia	

Category 3

If you are not a citizen of a country listed in one of the two charts above, your SSDI payments will stop after you have been outside the United States for six calendar months, unless one of the following is true:

- You were eligible for monthly Social Security benefits in December, 1956.
- You are in the active military service of the United States.

- The worker on whose record your benefits are based had done railroad work qualifying as employment covered by the Social Security program (see Chapter 2, Section D, regarding the Railroad Retirement Act and the Social Security program).
- The worker on whose record your benefits are based died while in U.S. military service or as a result of a service-connected disability and was not dishonorably discharged.
- You are a resident of a country listed below with which the United States has a Social Security agreement. Note that the agreements with Austria, Belgium, Germany, Sweden and Switzerland permit you to receive benefits as a dependent or survivor of a worker while you reside in the foreign country only if the worker is a U.S. citizen or a citizen of the foreign country.

Australia	Germany	Portugal
Austria	Greece	South Korea
Belgium	Ireland	Spain
Canada	Italy	Sweden
Chile	Luxembourg	Switzerland
Finland	Netherlands	United Kingdom
France	Norway	

- The worker on whose record your benefits are based lived in the United States for at least ten years or earned at least 40 earnings credits under the U.S. Social Security system, and you are a citizen of one of the following countries:

Afghanistan	Honduras	St. Vincent and Grenadines
Australia	India	Senegal
Bangladesh	Indonesia	Sierra Leone
Bhutan	Kenya	Singapore
Botswana	Laos	Solomon Islands
Burundi	Lebanon	Somali Dem. Rep
Cameroon	Lesotho	South Africa
Cape Verde Islands	Liberia	Sri Lanka
Central African Rep.	Madagascar	Sudan
Chad	Malawi	Swaziland
China	Malaysia	Taiwan
Congo Rep.	Mali	Tanzania
Ethiopia	Mauritania	Thailand
Fiji	Mauritius	Togo
Gambia	Morocco	Tonga
Ghana	Myanmar	Tunisia
Haiti	Nepal	Uganda
	Nigeria	Yemen
	Pakistan	

Children who cannot meet the residency requirement on their own may be considered to meet it if the worker and other parent (if any) meet the requirement. Children adopted outside the United States will not be paid outside the United States, however, even if the worker meets the residency requirement.

The residency requirement will not apply to you if one of the following applies:

- You were initially eligible for monthly benefits before January 1, 1985.
- You are a citizen of Israel or Japan.
- You are a resident of a country listed below with which the United States has a Social Security agreement.

Australia	Germany	Portugal
Austria	Greece	South Korea
Belgium	Ireland	Spain
Canada	Italy	Sweden
Chile	Luxembourg	Switzerland
Finland	Netherlands	United Kingdom
France	Norway	

- You are entitled on the record of a worker who died while in the U.S. military service or as a result of a service-connected disease or injury.

c. How Payments Are Made When You Live Outside the U.S.

Normally, Social Security benefits can be paid to qualifying U.S. citizens and noncitizens who move outside of the United States. Unless you are a U.S. citizen who never plans to reside in another country, it is important that you understand the basics of how international payments are made. Banking technology permits the SSA to establish direct deposit to pay beneficiaries who reside in certain countries through International Direct Deposit (IDD) or Electronic Benefits Transfer (EBT). IDD and EBT will eventually be expanded to cover many countries.

IDD involves the assistance of a sponsoring or processing bank—either the central bank of the foreign country or a large commercial bank in that country. Payments are deposited directly into your account at the financial institution in that country, in that country's currency. The benefits are calculated in U.S. dollars. They are not increased or decreased because of changes in international exchange rates. IDD is

available in Anguilla, Antigua and Barbuda, Argentina, Australia, Austria, Bahama Islands, Barbados, Belgium, British Virgin Islands, Canada, Cayman Islands, Cyprus, Denmark, Dominican Republic, Finland, France, Germany, Grenada, Haiti, Hong Kong, Ireland, Italy, Jamaica, Malta, Netherlands Antilles, New Zealand, Norway, Portugal, St. Lucia, St. Vincent and the Grenadines, South Africa, Spain, Sweden, Switzerland, Trinidad and Tobago and the United Kingdom.

Electronic Benefits Transfer (EBT) allows you to have payments deposited in a special account in a U.S. bank. You can withdraw the benefits by using a bank card at an automated teller machine (ATM) in the country in which you reside. You can't write checks on the account, nor can you add funds to the account. EBT is only currently available in Argentina. SSI payments are available through EBT, but not IDD.

When you move from one country to another, the way your benefits will be paid depends on the countries involved.

You move from the U.S. to an IDD country. If you move to an IDD country, the SSA will encourage you to open an account in the new country and receive payments in the new account. Until you open your new account, the SSA will make deposits to your old account. If you close your old account before you open your new one, the SSA will pay you by check until you open the new account. In either event, contact the Federal Benefits Unit at the U.S. embassy in the country to which you move to get enrolled in IDD. Although you don't have to open an account, for reasons previously discussed, it is in your best interest to receive your benefits by IDD rather than by check.

When you return from the IDD country, the IDD cannot continue while you have a U.S. address. As soon as you return, open up a U.S. bank account and let the SSA know so it can arrange direct deposit into that account.

You move from the U.S. to a non-IDD country. If you move from the U.S. to a non-IDD country, the SSA will encourage you to keep your bank account in the United States open (or to open one in an IDD country) to receive direct deposits. You can then access your U.S. account from overseas with an ATM card. If you don't have a bank account, the SSA will send you a check—unless you live in a prohibited country. (See sidebar.)

If You Move to a Prohibited Country

U.S. Treasury Department regulations prohibit sending payments to you if you are in Cuba or North Korea. In addition, Social Security restrictions prohibit sending payments to you if you are in Cambodia, Vietnam or areas that were in the former Soviet Union (other than Armenia, Estonia, Latvia, Lithuania and Russia). Not only can't the SSA send payments to these countries, federal regulations bar you from receiving payments even by direct deposit or through a representative.

If the SSA does learn that you are in Cuba or North Korea and stops payments, when you return the SSA will send you the money it withheld while you were away, but only if you are a U.S. citizen. If you are not a U.S. citizen, generally you cannot receive payments for the months you lived in Cuba or North Korea.

Payment dates and amounts are a frequent source of confusion for overseas beneficiaries. Regular IDD SSDI payments generally are made on the third of the month. If that date is a nonbusiness day in the foreign country, payments generally are made the next business day.

PMA (prior monthly accrual) SSDI payments are made on either the 12th or the 26th of the month. The PMA is a combined payment for all benefits due to you at the time your award is processed, and is paid immediately, subject to any delays by the U.S. processing partner, the Federal Reserve Bank of New York. The cutoff date for figuring out the PMA is about a week before the PMA payment date. PMA payments that arrive after the cutoff are scheduled for the next PMA payment date. Because the PMA payment includes the prior months' benefit, it could erroneously appear that these benefits are being paid incorrectly—especially because the check could arrive or be deposited after your first full monthly benefit check.

d. Reporting Changes While Living Outside the U.S.

When you live outside the U.S., you do not avoid the SSA's continuing disability reviews—a periodic process to determine whether you are still eligible for benefits.

The SSA will send you a questionnaire to fill out and return. You must return it to the office that sent it to you as soon as possible; if you do not, your payments will stop. (See Chapter 14.)

In addition to responding to the questionnaire, you are responsible for notifying the SSA promptly about changes that could affect your payments. If you fail to report something or deliberately make a false statement, you could be penalized by a fine or imprisonment. You may also lose some of your payments if you do not report changes promptly.

To report changes, contact the SSA in person, by mail or by telephone. If you choose mail and you live in Canada, send your report to the nearest U.S. Social Security office. In Mexico, send your report to the nearest U.S. Social Security office, embassy or consulate. In the Philippines, send your report to Veterans' Affairs Regional Office, SSA Division, 1131 Roxas Boulevard, Manila, Philippines.

In all other countries, you can contact the nearest U.S. embassy or consulate. If you'd rather send your report to the SSA in the U.S., ship it via airmail to Social Security Administration, P.O. Box 17769, Baltimore, Maryland 21235-7769, USA.

In reporting a change, include all of the following information:

- name of person or persons about whom the report is being made
- what is being reported and the date it happened, and
- the claim number on the Social Security check (the nine-digit Social Security number followed by a letter, or a letter and a number).

6. You Receive Other Disability Benefits

If you are disabled and under 65, Social Security benefits for you and your family may be reduced if you receive workers' compensation or black lung payments or disability benefits from certain government programs. Let the SSA know if any of the following are true:

- you apply for another type of disability benefit
- you begin receiving another disability benefit or a lump-sum settlement, or
- you already receive another disability benefit and the amount changes or stops.

7. You Get a Pension From Work Not Covered by Social Security

Let the SSA know if you start receiving a pension from a job where you did not pay Social Security taxes. For example, state workers covered under a state or local retirement system may receive pension benefits related to work that did not require the payment of Social Security taxes. Whether a particular state employee is covered under Social Security can vary from state to state and the type of agreements the particular state has entered into with the federal government. If you are not sure about your own situation, contact the official who manages your retirement plan.

Also, if you receive U.S. Social Security disability benefits and start to receive a monthly pension which is based in whole or in part on work not covered by the U.S. Social Security system (such as a foreign social security pension), then your U.S. Social Security benefit may be smaller because the SSA may use a secondary formula to figure your U.S. Social Security benefit. For more information, ask at any U.S. embassy or Social Security office.

8. You Are a Spouse or Surviving Spouse Who Receives a Government Pension

If you are a disabled widow or widower or the spouse of someone getting disability benefits, your Social Security payments may be reduced if you worked for a government agency where you did not pay Social Security taxes and you receive a pension from that agency. Notify the SSA if you begin to receive such a pension or if the amount of that pension changes.

9. You Get Married

Marriage may affect your disability benefits. Be sure to notify the SSA in the following situations:

- **You are an adult who was disabled before age 22 and receive benefits on the Social Security record of a parent or grandparent.** Payments generally will end unless you marry a person who receives

certain Social Security benefits. Specifically, your benefits will not end if you are age 18 or older, disabled, and you marry a person entitled to child's benefits based on disability or a person entitled to old age, divorced wife's, divorced husband's, widow's, widower's, mother's, father's, parent's or disability benefits. Once your benefits end, they cannot start again unless the marriage is declared void. A void marriage is one that was illegal from the outset, such as if you marry someone who is already married. If your marriage ends in a divorce or your spouse dies, you won't be eligible to have the benefits restart.

- **You receive benefits as the child of a disability recipient.** Your benefits will end when you marry.
- **You receive benefits on your own earnings record.** Your payments will continue and you don't need to report the marriage. But, report any change of name so it will appear on your future mailings.
- **You receive benefits as a disabled widow or widower.** Payments will continue, but remember to report any name change. If your current spouse dies, you may be eligible for higher benefits on his or her work record.

10. You Get a Divorce or Annulment

Notify the SSA if your marriage is annulled or you get divorced. Divorce or annulment does not necessarily mean that your SSDI payments will stop. If you are receiving payments based on your own work record, divorce or annulment of your marriage will not affect your payments. Also, if you are a spouse age 62 or older and you were married to the worker for ten years or more, your payments will continue even if you divorce. But still contact the SSA if your name is changed as a result of the divorce so that the SSA can put your new name on your payments.

11. You Cannot Manage Your Funds

If you become unable to manage your funds, you must appoint a person or organization, called a representative payee, to receive and use the benefits on your behalf. The payee is responsible for the following:

- properly using the benefits on your behalf
- reporting to the SSA any events that may affect your payments, and
- completing reports required by the SSA.

If you appoint a representative payee because you have a drug or alcohol addiction, the SSA may refer you to a state substance abuse agency for treatment.

Note that if you have appointed someone to manage your finances or healthcare under a power of attorney, that person will not be qualified as representative payee by virtue of the power of attorney. You must separately notify the SSA. Also, a representative payee is not the same as an attorney or other representative who may help you pursue your claim.

12. You Are Convicted of a Crime

If you are convicted of a crime, the SSA should be notified if you are imprisoned or confined to an institution. Benefits generally are not paid while you are imprisoned or institutionalized, although any family members eligible on your record may continue to receive benefits.

Confinement to an institution without conviction does not result in a suspension of benefits, but must result from a court or jury finding one of the following:

- guilty, but insane
- guilty by reason of insanity or similar factors (such as mental defect or incompetence), or
- incompetent to stand trial.

(Also see Section E4 regarding other law applicable to prisoners.)

13. Recipient Dies

You must notify the SSA when an SSDI recipient dies. The deceased's survivors are not entitled to keep the payment for the month in which the death occurred. For example, if Herman died in June, even June 30th, Herman's survivors must return the July payment, which is actually the June benefit. If Herman and his wife Eloise receive a joint monthly payment, however, Eloise should contact the SSA before returning the payment, as she's entitled to a portion of it.

If the SSA was depositing the benefit directly into the recipient's bank account, be sure to notify the bank so it can return any payments received after death.

If the deceased's family members received benefits on the deceased's record, those payments will change to survivors' benefits. If a worker received benefits on behalf of children, the family will have to appoint a new representative payee for the children. The survivors will need to provide a death certificate or other proof of death to the SSA.

14. Child Reaches Age 18

Payments to a child will stop when the child reaches age 18 unless he or she is unmarried and either disabled or a full-time student at an elementary or secondary school.

Twice a year the SSA sends each student a form to be filled out and returned. If the form is not sent back, the student's payments will stop. In addition, if a child age 18 or over receives payments as a student, be sure immediately to notify the SSA if the student:

- drops out of school
- changes schools
- changes attendance from full-time to part-time
- is expelled or suspended
- is paid by his or her employer for attending school
- marries, or
- begins working.

If a child whose payments were stopped at age 18 either becomes disabled before age 22 or is unmarried and enters elementary or secondary school full-time before age 19, the SSA can resume sending payments to the child. Also, a disabled child who recovers from a disability can have payments started again if he or she becomes disabled again within seven years.

15. Changes in Parental or Marital Status

If you adopt a child, let the SSA know the child's name and the date of the adoption. The child may be entitled to auxiliary benefits. Also, payments to a child who is not a U.S. citizen could stop or start if the child's natural or adoptive parent or stepparent dies, marries or gets a divorce (or annulment), even if the parent does not receive SSDI payments.

16. Child Leaves Your Care

If you receive benefits as a wife, husband, widow or widower caring for a child who is under age 16 or who was disabled before age 22, notify the SSA as soon as the child leaves your care. Failure to report this could result in a penalty and an additional loss of benefits. A temporary separation does not affect your benefits as long as you retain parental control over the child. Also, let the SSA know if the child returns to your care.

17. Deportation or Removal From the U.S.

If you are not a U.S. citizen, and are deported or removed from the U.S. for certain reasons, your Social Security benefits are stopped and cannot be started again unless you are lawfully admitted to the U.S. for permanent residence. Even if you are deported or removed, your dependents can receive benefits if they are U.S. citizens.

If your dependents are not U.S. citizens, they can still receive benefits if they stay in the U.S. for the entire month. But they cannot receive benefits for any month if they spend any part of it outside the U.S.

C. Reporting Changes—SSI Recipients

Your obligation to report any changes that may affect your SSI benefits is similar to the requirements described for SSDI recipients, with a few differences. For example, residents of California, Hawaii, Massachusetts, Michigan, New York or Vermont have special reporting requirements described in Section C10, below.

You must report any required change within ten days after the month it happens. For example, if you move on November 5th, you must let the SSA know by December 10th. If you receive your benefit by check, to make sure your check goes to your new address, notify the SSA of any address change as soon as you can. Suppose you always receive your SSI check on the 3rd of the month. As in the above example, if you move on November 5th and don't tell the SSA until December 10th, your December 3rd check will go to your old address. This could cause you serious problems.

The SSI law has specific penalties for failing to make timely reports. These penalties can be deducted from your benefits—and you'll still have to return any overpayments. The penalty is \$25 for the first failure to timely report, \$50 for the second time and \$100 for each subsequent failure. Penalties will not be assessed if you were without fault or had good cause for the failure to report.

This section describes only the situations in which reporting changes are different for SSI recipients than for SSDI recipients. Be sure to read Section B first.

1. You Change the Number of People With Whom You Live

The SSA insists on knowing the number of people who live with you. This means that you must tell the SSA if someone moves into or out of your home, if someone you live with dies or you or someone you live with has or adopts a baby.

2. Your Income Changes

If you had a source of income other than your SSI when you applied for benefits, and the amount of that other income changes after you begin receiving SSI, tell the SSA. Similarly, if you start receiving income from another source while you are on SSI, you must tell the SSA. If you are married, you must notify the SSA if your spouse's income changes.

If your child under age 18 lives with you and receives SSI, notify the SSA of any of the following:

- changes in the child's income
- changes in your income
- changes in the income of your spouse
- changes in the income of a child who lives with you but does not get SSI
- the marriage of a child who lives with you but does not get SSI, and
- changes in the student status (starts or stops attending school full-time) of a child who is working or is age 18 to 20 and lives with you.

Changes in household income generally mean that your SSI benefit will be recalculated; the new amount will affect your SSI check two months later.

If you also receive Social Security SSDI or retirement benefits, you don't have to notify the SSA of changes in those benefits. But, if your spouse gets Social Security SSDI or retirement benefits, you do have to tell the SSA about benefit changes.

For SSI purposes, income includes cash, checks and the equivalent that can be used for food, clothing or shelter. It even includes items you wouldn't have to report for federal, state or local income taxes. The following are examples of income:

- wages from a job
- net earnings from your own business
- value of any food, shelter or clothing that someone provides for you
- money for food, shelter or clothing (excluding food stamps and housing allowances)
- annuity or pension payments
- veterans' benefits, railroad retirement and railroad unemployment benefits
- workers' compensation, unemployment, black lung or SSDI benefits
- prizes, settlements and awards, including court awards
- life insurance proceeds
- gifts and contributions
- child support and alimony
- inheritances
- interest and dividends earned on deposit accounts and investments
- rental income, and
- strike pay and other benefits from unions.

The following items are *not* considered income by the SSA:

- medical care
- social services
- cash from selling, exchanging or replacing items you own
- income tax refunds
- earned income tax credit payments
- payments from life or disability insurance on charge accounts or other credit accounts.
- bills paid by someone else for things other than food, clothing or shelter
- proceeds of a loan
- replacement of lost or stolen items
- weatherization assistance (for example, insulation, storm doors, windows), and

- credit life and credit disability insurance policies issued to or on behalf of borrowers, to cover payments on loans in the event of death or disability.

EXAMPLE: Frank Fritz, an SSI recipient, purchased credit disability insurance when he bought his home. Subsequently, Mr. Fritz was in a car accident and became totally disabled. Because of his disability, the insurance company paid off the home mortgage. Neither the payment nor the increased equity in the home is considered income to Mr. Fritz.

Some things the SSA normally counts as income are not counted as income under certain conditions—such as food, clothing, shelter or home energy assistance provided free or at a reduced rate by private nonprofit organizations. But you still must tell the SSA about income that you think falls in the “not counted” category; the SSA makes that judgment.

3. You Obtain Assets

To qualify for SSI, a single person can own up to \$2,000 of property and a married couple can own as much as \$3,000 worth. If you (or your spouse, if you are married or your child if your child receives SSI) acquire property and the total value of what you own exceeds these limits, you must tell the SSA. You don't have to include property not counted toward these limits, such as your home. (See Chapter 1, Section A2.)

If you receive checks from the SSA to cover periods you were eligible for but did not receive SSI or SSDI, those payments won't be counted for the six months after the month you get the money. However, if you have any money left over after the six-month period, it will count. For example, Jillian starts receiving SSI on March 3; her first payment includes an extra \$2,000 to cover the time she qualified for SSI before her payments began. If she has any of this money left over after September 3, she must tell the SSA. The SSA will consider it income and count it toward her eligibility for future SSI benefits.

If you agreed to sell property to qualify for SSI, notify the SSA when you sell it. If you don't sell the

property, you may not be eligible for SSI and you may have to return checks already sent to you.

If your name gets added to a bank account with another person, the SSA will probably consider all the money yours even if it isn't. If someone wants to add your name to an account, check with the SSA first. If the money is not yours or is for a special purpose such as paying your medical expenses, the SSA can tell you how to set up the account so it will not affect your SSI.

4. You Enter or Leave an Institution

You must tell the SSA if you enter or leave a residential institution, hospital, skilled nursing facility, nursing home, intermediate care facility, halfway house, jail, prison, public emergency shelter or similar kind of institution. The SSA needs the name of the institution and the date you enter or leave. If you can't contact the SSA, ask someone in the institution's office to help you.

In most cases, you cannot get SSI while you are in an institution. If you enter a medical institution, however, your SSI can probably continue if your stay is for 90 days or fewer. Your doctor must sign a statement about how long you will stay, and you must sign a statement that you need to pay expenses for your home while you're in the institution. The SSA must receive both statements by the 90th day you are in the institution, or the day you leave if that's earlier.

5. You Marry, Separate or Divorce

You must let the SSA know of any change in your marital status—that is, you marry, divorce, separate or get back together after a separation. These changes can affect your income and, therefore, possibly the amount of your SSI benefits.

6. You Leave the U.S.

If you leave the U.S. for 30 days or more, you usually can no longer get SSI. You are obligated to notify the SSA before you leave of the dates you will be gone.

Once you return, your checks can't start again until you have been back in the U.S. for at least 30 continuous days.

Dependent children of military personnel who leave the U.S. may continue to get SSI while overseas if they were receiving SSI in the month before the parent reported for overseas duty.

7. You Are a Sponsored Immigrant

If you qualified for SSI as an immigrant sponsored by a U.S. resident, then when deciding whether you qualified for SSI, the SSA considered the income and assets of the following people:

- you (including items you own in your homeland)
- your spouse
- your parents if you are under 18
- your sponsor, and
- your sponsor's spouse.

For the five years after you enter the U.S., you must report any changes in the income and assets of these people. After the five-year period, you have to report only changes in the income and assets of you, your spouse and your parents if you are under 18.

This rule doesn't apply if you are a refugee or have been granted asylum. The rule also does not apply if you become blind or disabled after being lawfully admitted for permanent residence in the U.S. Note that if you are not a citizen, the date you physically entered the U.S. is not necessarily the same as the date in which you technically became "lawfully admitted" as a permanent resident.

8. You Are Under Age 22 and Start or Stop Attending School

If you are under 22, notify the SSA of any date you start or stop attending school on a full-time basis.

9. You Become Addicted to Drugs or Alcohol

If you receive SSI based on disability and you become addicted to drugs or alcohol, the SSA may refer you to

a state substance abuse agency for treatment. (Also, see Section E4 regarding new law affecting DAA cases.)

10. You Live in California, Hawaii, Massachusetts, Michigan, New York or Vermont

Residents of California, Hawaii, Massachusetts, Michigan, New York and Vermont have additional reporting requirements that can affect your benefits.

- **California and New York.** You must let the SSA know if you were regularly eating your meals away from home and you now eat at home, or you were regularly eating at home and you now eat out. Additional state payments may be available to people who cannot cook or store food where they live or who are unable to cook for themselves. “Regularly” means where you must eat, not how often you eat in one place or another. If you are able to prepare meals at home but eat out frequently, you are considered to regularly eat at home and you would not qualify for extra benefits because where you eat is a matter of choice, not necessity. The actual rules are extremely complex; report any change affecting your ability to prepare meals at home—including broken appliances.
- **New York.** You must inform the SSA if you live or lived with others, and you used to prepare your meals alone and now you prepare meals together, or if you were preparing your meals together and now you prepare them alone. The state is interested in the cost of your meal preparation because meals can be more expensive under some circumstances than others. The change in cost can affect the amount of the state’s SSI supplement.
- **Hawaii, Michigan and Vermont.** You must notify the SSA if you live in a facility that provides different levels of care, and the level of care you receive changes. For example, Bernadette lives in a home that provides both assisted living and skilled nursing. Her health has deteriorated and she has been moved from the assisted living

unit to the skilled nursing section. She must notify the SSA. Generally, if you are in a nursing home or other medical facility where Medicaid pays for more than half of the cost of your care, your federal SSI payment is limited to \$30 a month. But some states’ supplemental payment rules differ depending on the type of facility in which you live. If your level of healthcare changes, contact the SSA. You could be entitled to considerably more than \$30 per month. (See also Chapter 3 regarding children in such facilities.)

- **Massachusetts.** You must let the SSA know if you (or you and your spouse) were paying more than two-thirds of your household’s living expenses and now you pay less, or if you were paying less than two-thirds, but now you pay more. The proportion of living expenses you pay is relevant to how your living arrangement will be classified, and this can affect the amount of your supplemental benefit.

D. Returning to Work

After you start receiving SSDI or SSI, you may want to try to return to work. The decision, of course, is yours. But if you think you can work, you probably feel like most people, who see working as more than just an opportunity for extra cash. They cite satisfaction from overcoming a disability through their skills, connecting with people and getting back into the mainstream.

But returning to work is a big step for a person with a disability. Questions and concerns may be swirling around in your head: “How will my benefits be affected?” “Will I lose my Medicare or Medicaid?” “What if I need special equipment at work?”

Special rules called work incentives can help you ease back into the workforce. These work incentives include:

- cash benefits while you work
- medical coverage while you work
- help with expenses incurred by your employer because of your disability, and
- help with education, training and rehabilitation.

1. SSDI Work Incentives

The SSDI work incentives are fairly extensive.

Trial work period. If you return to work, during the first nine months you will continue to receive your SSDI benefits. At the end of nine months of work, the SSA will decide if you are doing substantial gainful activity (SGA)—earning an average of at least \$800 per month in 2003. If you are self-employed, your income may not be the best measure of whether you are doing SGA. Often, more consideration is given to the amount of time you spend in your business than to the amount of your income. If the SSA believes you are doing SGA, you will receive benefits for three more months and then they will stop.

Not all work counts toward the nine-month period. Generally, a month will count if you earn over \$570 in gross wages (regardless of amount of time worked) or spend 80 hours in your own business (regardless of amount of earnings). In addition, for the SSA to consider stopping your benefits because you have worked for nine months, the nine months need not be in a row, but they must take place within a 60-month period. Note that these rules are different, and more lenient, from those used by the SSA to determine whether you are doing SGA *outside* of a trial work period. Issues involving the trial work period or SGA can be confusing and complex. If you have any questions, do not hesitate to call your local SSA Field Office.

Extended period of eligibility or re-entitlement period.

If you are still disabled but you return to work for more than nine months and your benefits stop, you receive a special protection for the next 60 months. During that time, the SSA will pay you your SSDI benefit in any month you earn below the SGA level, even if you stop working for a reason unrelated to your disability—for instance, you get laid off. You do not have to file a new application; you simply notify the SSA. If you stop working again because of your disability, your benefits will resume without your having to reapply. (See Section E1, below.)

Resumption of benefits if you become disabled again.

If you return to work and become disabled again within five years after your benefits were stopped, they can begin again following the first full month you are disabled. Although the SSA does not have to

redetermine your eligibility, you do have to complete a new application. If you are a disabled widow or widower or a person disabled before age 22 who returns to work and becomes disabled again within seven years, you can simply complete a new application for your benefits to resume.

Continuation of Medicare. If you are still disabled but you return to work for more than nine months and your benefits stop, your Medicare coverage can continue for at least 8 and a half years. During this period, your hospital insurance coverage is free. After the 8 and a half years, you can buy Medicare coverage by paying a monthly premium. (See Section E3, below.) Of course, if you are covered by your employer's medical insurance, there will be no reason to buy the Medicare coverage.

In addition, if you get Medicare and have a low income and few resources, your state may pay your Medicare premiums and, in some cases, other out-of-pocket Medicare expenses such as deductibles and coinsurance. Only your state can decide if you qualify. To find out if you do, contact your local welfare office or Medicaid agency. Having the federal government pay for these additional medical expenses makes it easier to become self-supporting when attempting to leave the disability rolls.

Impairment-related work expenses. If you need certain equipment or services to help you work, the money you pay for them may be deducted from your monthly wages in calculating whether you are earning more than the SGA level. Generally included are the costs of equipment (such as a wheelchair or specialized work equipment), attendant care services (such as a personal attendant, job coach or guide dog), prostheses, prescription drugs or transportation to and from work. Remember that expenses you pay are deductible from your income as work expenses; expenses paid by your employer would not be deducted from your monthly wages to determine if you are earning more than the SGA level. If the deduction brings your monthly income to less than \$800, you'll receive your SSDI benefit and the month won't count toward your nine-month trial period, if you are still in your trial work period.

Recovery during vocational rehabilitation. If you participate in a vocational rehabilitation program that is meant to result in your becoming self-supporting, and

your disability ends while you are in the program, your benefits generally will continue until the program ends.

Special rules for blind persons. If you are blind and return to work, and earn above the SGA level for blind people (above \$1,330 per month for the year 2003), you are still eligible for a disability “freeze.” This means that the years in which you had low or no earnings because of your disability will not be counted in figuring your future benefits, which are based on your average earnings over your work life.

If you are 55 or older and you are blind, the SSA figures your ability to perform SGA differently. After age 55, even if your earnings exceed the SGA level, benefits are only suspended, not terminated, if your work requires a lower level of skill and ability than work you did before age 55. The SSA assumes that your ability to do SGA is low and that you sometimes may be unable to work because of your disability. Thus, your eligibility for Social Security benefits may continue indefinitely and the SSA will pay benefits for any month your earnings fall below the SGA level.

If you’re blind and self-employed, the SGA level becomes the only measure of SGA. The SSA does not make a separate evaluation of the time you spend in your business as it does for non-blind beneficiaries. This means you can be doing a lot of work for your business but still receive disability benefits as long as your net profit does not exceed the SGA level.

EXAMPLE: Pamela, age 24, was receiving disability benefits of \$557 a month based on a childhood condition that made it difficult for her to walk. She wanted to work, but was afraid of losing her benefits and Medicare. After learning about the disability work incentives, Pamela started working in a local laundry earning \$850 a month. Here’s how her income changed.

First nine months of work—no change

Gross earnings	\$850
Social Security check	+ 557
Total monthly income	<u>\$1,407</u>

Next three months of work

At the end of the nine months of work, the SSA determined that Pamela’s work was SGA—it averaged more than \$800 per month. Her benefits continued for three more months and then

stopped. (However, note that because Pamela is still considered disabled, her benefits could be reinstated anytime during the next 36 months if her earnings drop below \$800.)

Following the first year of work

During the first year after her trial work period, Pamela’s company relocated to a town not accessible by mass transit. She hired a neighbor to drive her to work and paid a coworker to bring her home. Her transportation expenses totaled \$120 a month. In addition, Pamela purchased a special motorized wheelchair so she could get around the new suburban plant. This cost \$75 a month.

Gross earnings	\$850
Transportation expenses	– 120
Wheelchair cost	– 75
Countable earnings	<u>\$655</u>

Because Pamela’s countable earnings were less than \$800 a month, the SSA reinstated her checks. Her total income changed as follows:

Countable earnings	\$655
Social Security check	+ 557
Total income	<u>\$1,212</u>

Following the second year of work

After another year, Pamela paid off the motorized chair and received a raise to \$990 a month.

Gross earnings	\$990
Subtract work expenses	– 120
Countable earnings	<u>\$870</u>

Because her countable earnings exceed \$800, her SSDI stopped. Her Medicare continued another 93 months past her trial work period.

The point of this example is to show that at each point in her working life, Pamela’s total income was greater than it would have been had she not worked and simply relied on disability benefits.

2. SSI Work Incentives

Like the SSDI work incentives, the SSI work incentives are quite extensive.

Continuation of SSI. If you return to work, you can continue to receive payments until your income exceeds the SSI income limits.

How Working Reduces Your SSI Amount

If your only income other than your SSI payment is money from a job, the SSA doesn't count the first \$85 in earnings you get each month. One-half of what you earn over \$85 is deducted from your SSI check. If you have income in addition to job earnings and SSI, the SSA doesn't count the first \$65 in job earnings you get each month. One-half of what you make over \$65 is deducted from your SSI payment. So is your other income, less \$20.

If you have no income other than job earnings and SSI, you could earn over \$1,000 a month before your SSI will stop. The exact amount depends on your state. If you have income in addition to job earnings and SSI, the amount you can earn before losing your SSI payment may be lower. If your job earnings are more than \$800 a month, you are considered able to engage in substantial gainful work and not eligible for SSI based on disability.

If you lose your job while you are still getting SSI, your payments will increase because of the loss of income. If you lose your job within 60 months of when your SSI payments stopped because your earnings were too high and you are still disabled, your benefits will start again without your having to reapply. If you lose your job after working more than 12 months from when your SSI stopped, you may have to reapply. (See Section E1, below.)

Continuation of Medicaid. If you return to work, your Medicaid coverage will likely continue until your income reaches a certain level. The level varies from state to state and reflects the cost of healthcare in your state. If your actual healthcare costs are higher than the average for your state, you may be able to keep your Medicaid. Be aware, however, that for Medicaid to continue, you must:

- need it to work
- be unable to afford similar health insurance coverage
- have a disabling condition, and
- meet the nonincome SSI disability requirements.

In addition, if you have low income and few resources, your state may pay your Medicaid premiums and, in some cases, other out-of-pocket Medicaid expenses such as deductibles and coinsurance. (See Section E3 for new law liberalizing state assistance with Medicaid expenses.)

Plan for Achieving Self-Support. A special SSA rule called a "Plan for Achieving Self-Support," or PASS, lets you put aside money and assets toward a plan designed to help you support yourself. The money won't be counted toward your SSI eligibility and won't reduce your SSI payment. The goal of your plan may be to start a business or get a job.

If you go back to work and your income exceeds the SSI eligibility level, a PASS may help you qualify. You can set aside income and assets you need to accomplish a work goal, and reduce the money counted by the SSA toward your SSI eligibility or benefit amount.

Your vocational rehabilitation worker, your employer, an SSA staff person or anyone else can help you write up a PASS. In general, the PASS must:

- **be in writing**, preferably on form SSA-545, and signed by the individual, and, if applicable, the representative payee
- **state a specific work goal**, one that you have a reasonable chance of achieving given your strength and abilities (e.g., "becoming a carpenter" or a "computer programmer," but not "getting a degree" or "buying a car")
- **show a reasonable time frame**, including your projected beginning and ending dates, milestones along the way and a last step that indicates how you'll get a job, and
- **specify the amount and sources of income or resources to be set aside**, including a description of expenses (reasonably priced) that are necessary to achieve the work goal.

EXAMPLE: Delano receives SSI payments of \$552 each month. It is his only income. He is offered a job in a local fast food restaurant at \$215 per month, and contacts his local SSA office to see how this would affect his SSI payment. He is told that Social Security would not count the first \$85 of earnings and only half of the earnings over \$85.

Gross monthly earnings	\$215
First \$85	– 85
Earnings over \$85	<u>\$130</u>
Half of earnings over \$85	\$ 65
SSI payment	\$552
Half of earnings over \$85	– 65
New SSI award	<u>\$487</u>
Gross monthly earnings	+ 215
Total monthly income	<u>\$702</u>

After working 18 months, Delano gets a raise to \$367 a month. He also purchases an electric wheelchair to help him get around at work, which he pays off at \$52 a month.

Gross monthly earnings	\$367
First \$85	– 85
Earnings over \$85	<u>282</u>
Wheelchair cost	– 52
Balance	<u>\$230</u>
Half of balance	\$115
SSI payment	\$552
Half of balance	– 115
New SSI award	<u>437</u>
Gross monthly earnings	+ 367
Total monthly income	<u>\$804</u>

Even though Delano's earnings went up by \$152, his SSI payment was reduced by only \$50 because of the work expense deduction for the wheelchair. And his total income now is \$804, substantially more than the \$552 he had before he started working.

After a few more months, Delano decides that he wants to get a college degree. His sister helps him write a PASS describing his plans to work and save money for school. He wants to save \$75 each month for school.

Gross monthly earnings:	\$367
First \$85	– 85
Earnings over \$85	<u>282</u>
Work expenses	– 52
Balance	<u>\$230</u>
Half of balance	\$115
	– 75
PASS savings plan	<u>\$40</u>
SSI payment	\$552
PASS adjustment	– 40
New SSI award	<u>512</u>
Gross monthly earnings	+ 367
Total monthly income	<u>\$879</u>

Even though Delano's job earnings didn't change, his SSI checks increased because of the PASS.

Work expenses related to your disability. If you need certain equipment or services to help you work, the money you pay for them may be deducted from your monthly wages to determine your income level. Generally included are the costs of equipment (such as a wheelchair or specialized work equipment), attendant care services (such as a personal attendant, job coach or guide dog), prostheses, prescription drugs or transportation to and from work. Remember that expenses you pay are deductible from your income as a work expense; expenses paid by your employer would not be deducted from your monthly wages to calculate if you are earning more than the SGA level. If you are blind, the work expenses need not be related to the impairment. Special rules for blind persons (see below) are even more favorable.

Recovery during vocational rehabilitation. If you participate in a vocational rehabilitation program that is meant to result in your becoming self-supporting and your disability ends while you are in the program, your benefits generally will continue until the program ends.

Sheltered workshop payments. If you work in a sheltered workshop, special rules allow the SSA to exclude some of your earnings when figuring your SSI payment.

Grants to disabled students. Most scholarships or grants used to pay for tuition, books and other expenses directly related to getting an education will not be counted as income if you go to school or

enroll in a training program. You may also exclude up to \$1,340 of earnings a month, up to \$5,410 a year in 2003. This amount is increased yearly.

Rules for blind persons. If you meet the medical definition of blind, SGA is not a factor for your SSI eligibility. Your SSI eligibility continues until you medically recover or the SSA ends your eligibility because of a nondisability-related reason.

Also, most of your work expenses—not just those related to your disability—are deducted from your income when the SSA decides you are eligible for SSI. For example, the cost of special clothes needed on the job can be deducted.

Some other examples of blind work expenses are:

- guide dog expenses
- transportation to and from work
- federal, state and local income taxes
- Social Security taxes
- attendant care services
- visual and sensory aids
- translation of materials into Braille
- professional association fees, and
- union dues.

EXAMPLE: Ahmed is 20 years old and receives SSI payments because he is blind. He receives \$552 each month and has Medicaid coverage.

In January, Ahmed begins working part-time during the evenings and on weekends for the veterinarian who cares for his guide dog. Ahmed is paid \$425 a month to answer the phone, make appointments and help with the care and feeding of animals boarded at the kennel.

Ahmed reports his work and earnings to his local Social Security office and reports the following blind work expenses:

Transportation to/from work	\$50.00
Care/feeding of his guide dog	+ 35.00
Taxes	+ 40.50
Total blind work expenses	<u>\$125.50</u>

Here is how SSA calculates Ahmed's SSI amount based on his earnings and his blind work expenses:

Gross monthly earnings	\$425.00
First \$85	– 85.00
Earnings over \$85	<u>\$340.00</u>
Half of earnings over \$85	\$170.00
Blind work expenses	– 125.50
Countable income	<u>44.50</u>
SSI payment	\$552.00
Countable income	– 44.50
	<u>\$507.50</u>

This means that, even though Ahmed is earning \$425 per month, he loses only \$44.50 in SSI payments, and his Medicaid coverage continues. Ahmed's total monthly income becomes \$932.50.

In late March, Ahmed reports to the SSA that his employer has asked him to work longer hours and also is giving him a raise. Ahmed begins earning \$700 per month in April. He tells SSA that he likes working with animals so much that he would like to go to school to learn to be a dog trainer and groomer. He plans to save \$225 per month from his increased earnings so that he will have \$1,125 saved to pay for books and tuition by September when the course begins at a local vocational school. The SSA helps Ahmed to write a PASS so that \$225 per month is excluded from the income used to figure his SSI payment for the months from April through August.

Additionally, Ahmed reports that working longer hours and earning more will increase his transportation costs and his taxes. He reports the following blind work expenses beginning with April:

Transportation to/from work	\$65.00
Care/feeding of his guide dog	+ 35.00
Taxes	+ 75.50
Total blind work expenses	<u>\$175.50</u>

Here is how SSA computes Ahmed's SSI payment beginning with April:

Gross monthly earnings	\$700.00
First \$85	– 85.00
Earnings over \$85	<u>\$615.00</u>
Half of earnings over \$85	\$307.50
Blind work expenses	– 175.50
Countable income	<u>\$132.00</u>
PASS adjustment	\$225.00
Countable income	\$0.00

Because SSA was able to deduct so many of his work expenses, none of Ahmed's income is subtracted. He receives \$552, the maximum SSI payment in his state. Even though Ahmed is earning \$275 more each month than he did in January, February or March, his SSI check will increase from \$507.50 to \$552 because of his PASS. His Medicaid coverage continues. Ahmed's total monthly income beginning in April is \$1,252.

Ahmed begins a four-month course to learn to be a dog groomer and trainer in September. His PASS ended in August because he had saved the \$1,125 to pay for books and tuition. But now he is an unmarried student under age 22 and he can use the student earned income exclusion to reduce his countable income. He can exclude earnings of \$1,340 per month up to a maximum of \$5,410 annually. Since he will be in school for only four months in the calendar year, he can use the exclusion for each of these months without exceeding the \$5,410 annual maximum.

Ahmed continues to work for the veterinarian and receives another pay raise, which increases his earnings to \$800 per month beginning in September. His blind work expenses for transportation and care and feeding of his guide dog are unchanged, but his increased wages cause his taxes to go up \$12. His total blind work expenses, beginning in September, rise from \$175.50 to \$187.50 per month, including the \$12 additional taxes.

Here is how SSA figures Ahmed's countable income while he is a student from September through December:

Ahmed's earnings	\$ 800
Student earned inc. exclusion	– 1,340
Countable income	<u>\$ 0</u>

Ahmed continues to receive \$552 per month from SSI in addition to his monthly earnings of \$800, and his Medicaid coverage continues. Ahmed's total monthly income becomes \$1,352.

E. Passage of the Ticket to Work and Work Incentives Improvement Act

A law called the Ticket to Work and Work Incentives Improvement Act (TWWIIA; Public Law 106-170) contains some provisions that affect how the SSA handles work incentives. The intention of the TWWIIA is to:

- increase the amount of choice disability recipients have in obtaining rehabilitation and vocational services to help them go to work and attain their employment goals
- remove the barriers that required people with disabilities to choose between healthcare coverage and work, and
- assure that more people with disabilities can participate in the workforce and lessen their dependence on public benefits.

Some of the more important highlights directly affecting disability recipients are described in this section. Although the law was enacted on December 17, 1999, individual provisions had much later effective dates, so portions of this program are still being set up. The SSA has also issued regulations interpreting the law, at 20 C.F.R. Part 411.

1. Elimination of Work Disincentives

Although the SSA already has work incentives as discussed previously, the intent of Congress in passing this law was to further encourage those receiving Social Security disability benefits to return to the workforce by eliminating additional financial obstacles.

a. Work Activity Standard As a Basis for Review

One of the obstacles to the disabled returning to work is benefit termination if you perform substantial gainful activities (SGA). The revisions don't take that away entirely, but they prohibit the SSA from using SGA as a means triggering a continuing disability review if a claimant has been receiving benefits for at least two years. All types of disability beneficiaries are affected. Regular, scheduled CDRs will still take place. This law:

- prohibits the use of SGA as a basis for review if you are entitled to disability insurance benefits under Section 223 of the Social Security Act (42 U.S.C.A. § 423) or monthly insurance benefits under Section 202 of the Social Security Act (42 U.S.C.A. § 402) and you have received such benefits for at least 24 months, and
- allows for regular CDRs and for the termination of benefits if you are earning more than the SGA.

b. Expedited Reinstatement of Benefits

By speeding up reinstatement of benefits in the event that people need to get back on disability quickly, these provisions may make claimants less reluctant to try working. Provisions of this law include:

- If your SSDI or SSI is terminated because you are doing SGA, you may request a reinstatement of benefits without filing a new application if you are not able to work on account of your medical condition and you file the reinstatement request within 60 months of when your benefits ended.
- While SSA is making a determination on your reinstatement request, you can receive provisional benefits for up to six months.
- If the SSA reinstates your benefits, you and your dependents still entitled to benefits would be reinstated at your old level.

2. Creation of New Work Incentives: Planning, Assistance and Outreach

These provisions direct the SSA to establish a community-based work incentives planning and assistance program for the purpose of providing accurate

information related to work incentives to disabled beneficiaries. Specifically, the SSA must:

- establish a program to provide benefits planning and assistance, including information on the availability of protection and advocacy services, to disabled beneficiaries
- conduct ongoing outreach efforts to disabled beneficiaries, and
- establish a corps of work incentive specialists within the SSA to provide information to disabled beneficiaries.

For information on how to reach such organizations in your state or U.S. territory, see:

- **Appendix D**, Benefits Planning Assistance Outreach Programs, and
- **Appendix E**, Protection and Advocacy Organizations.

3. Expansion of Healthcare Services

Loss of vital healthcare coverage is one of the biggest problems for the disabled trying to return to work. These provisions give additional assistance in decreasing health-cost barriers to working.

a. State Options Under Medicaid

For beneficiaries between 16 and 64, the law expands the states' options and funding for Medicaid for workers with disabilities by liberalizing the limits on resources and income and giving working people who have impairments the right to buy Medicaid, even though they are no longer eligible for SSDI or SSI. The states can require individuals to contribute to the cost on a sliding scale based on income.

This provision applies to medical assistance furnished on or after October 1, 2000.

b. Continuation of Medicare Coverage

Congress extended premium-free Medicare Part A coverage for SSDI beneficiaries who return to work for eight and one-half years (the prior length was four years).

This provision took effect October 1, 2000.

c. Election to Suspend Medigap Insurance

The law allows workers with disabilities who have Medicare coverage and a Medigap policy to suspend the premiums and benefits of the Medigap policy if they have employer-sponsored health coverage.

This provision applies to medical assistance furnished after the date of enactment, which was December 17, 1999.

4. Additional Amendments

Congress also added several technical amendments involving the SSA's handling of claims involving drug addicts and alcoholics, as well as prisoners.

a. Drug Addicts and Alcoholics

Congress expanded the law which authorizes the SSA to determine if a representative payee would be in the best interest of a disabled beneficiary who is incapable and has a drug addiction or alcohol condition. The SSA was also given expanded powers to determine whether such person should be referred to a state agency for substance abuse treatment services.

b. Prisoners

Several provisions under this law provide for incentive payments to institutions to report SSDI as well as SSI inmates to the SSA, shorten the length of confinement making an inmate ineligible for benefits, and address the issue of sexual predator confinement. The law:

- Extends the incentive payment provisions now in effect for SSI prisoners to SSDI recipients, and authorizes the SSA to report this information to any agency administering a federal or federally assisted cash, food or medical assistance program for purposes of determining program eligibility. These provisions—which already applied to SSI claimants—allow the SSA to pay \$200 to \$400 for information as a reward incentive for information that leads to a suspension of prisoner benefits.
- Eliminates the requirement that benefits end if confinement stems from a crime punishable by imprisonment for more than one year. Instead,

benefits would be suspended for any full month during which the person was confined because of a crime or a finding of not guilty by reason of insanity.

EXAMPLE: An SSDI beneficiary is arrested and confined in jail on March 21. He is not granted bail and is sent to trial. The court convicts the beneficiary on April 15. He is not released from jail once convicted, and is sent to prison on April 16. Under benefit suspension provisions, the beneficiary is considered convicted and confined on April 15. He must serve over 30 continuous days in an institution before the SSA will suspend his benefits. The period of time in jail prior to conviction is not considered when determining what date to suspend benefits.

Certain provisions apply only to prisoners whose confinement began on or after April 1, 2000. The law prohibits the payment of benefits to any SSDI beneficiary who, upon completion of a prison term, remains confined by court order to a public institution based on a finding that the person is sexually dangerous or a sexual predator.

F. Participation in the Ticket to Work Program

The SSA is now in the early stages of implementing the Ticket to Work program. Depending on whether you are eligible and whether your state's program is up and running, you may be able to participate.

1. Can You Participate in the Ticket to Work Program?

You are eligible to participate in the Ticket to Work Program if you are either a Title 2 (SSDI) or Title 16 Social Security beneficiary between 18 and 64 years of age and:

- your case has not been designated as one that will receive diary review (because medical improvement is expected), or

- your case has been designated as a medical improvement expected diary review case, but you have been through at least one continuing disability review (CDR) and the SSA made a final determination that your disability is continuing.

Also, for you to participate, the program must already be available in your state. For information on where it is available, see the box below, “State Participation Schedule.”

State Participation Schedule

The program is being phased in nationally over a three-year period. The first phase began in February 2002, when the SSA distributed tickets in the following 13 states: Arizona, Colorado, Delaware, Florida, Illinois, Iowa, Massachusetts, New York, Oklahoma, Oregon, South Carolina, Vermont and Wisconsin.

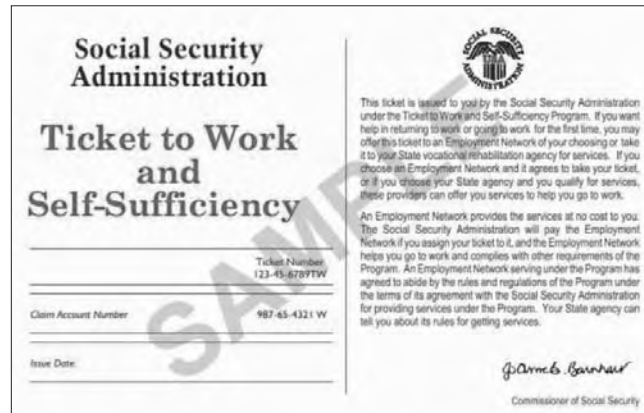
During the second phase, taking place later in 2002, the SSA distributed tickets in the following 20 states: Alaska, Arkansas, Connecticut, Georgia, Indiana, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, South Dakota, Tennessee, Virginia and the District of Columbia.

During the third phase, in 2003, the SSA will distribute tickets in the following 17 states: Alabama, California, Hawaii, Idaho, Maine, Maryland, Minnesota, Nebraska, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, Utah, Washington, West Virginia, Wyoming, as well as in American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the Virgin Islands.

2. Should You Participate?

First, understand that the Ticket to Work Program is *voluntary*. Its purpose is to offer you greater choice when it comes to finding work or earning more money—not to force you into working. If you decide that you are not interested in the program, or are not able to work, you do not have to take part. Your decision will have no effect on your disability benefits.

In the hopes that you will participate, the SSA has sent out several million letters along with what they call “tickets,” which you can use to access services. Millions of additional tickets will be mailed out in the future. If you haven’t already received a ticket, you may still be in line for one, provided that you are eligible.



You should only receive one ticket. However, it is also possible that you could receive a new ticket, or even multiple tickets over your lifetime, if your benefits are stopped and then restarted.



Don't toss your ticket. Even if you don't think you want to take part in this program now, keep any ticket the SSA sends to you in a safe place. Having this ticket will make things easier if you decide later to take part in the program.

3. Getting a Ticket

If you are interested in taking part in the Ticket to Work Program, but haven't yet received a ticket and think you should have, call MAXIMUS, Inc. at 866-968-7842 (TTY 866-833-2967). MAXIMUS is a private company that is working with SSA to help manage the program. MAXIMUS can answer most of your questions about the Ticket Program, and can give you the names, addresses, and telephone numbers of employment networks in your area. MAXIMUS also has a website at www.yourtickettowork.com.

MAXIMUS will keep track of people who have tickets but have not yet begun participating in the program, and will pass this information along to the

employment networks that provide services. Therefore, an employment network may contact you directly, asking whether you want to participate. Of course, you can always say “no.”

4. Where You’ll Go for Services

Unlike previous SSA programs, you will no longer be referred directly to state vocational rehabilitation agencies for rehabilitation services. Instead, you’ll be able to use your ticket to go to an approved service provider of your choice, called an “employment network” (EN). The EN can be a private organization or a public agency (such as state vocational rehabilitation agency) that has agreed to work with SSA to provide vocational rehabilitation, employment, and other support services to assist beneficiaries in going to work and remaining on the job.



Shop around before you assign your ticket. You don’t need to sign up with the first EN whose door you enter. If there are more than one of them in your area, talk with their staff members about your goals and the services they provide. Make sure you’ve found an EN with which you’re comfortable before you hand over your ticket.

5. What to Expect From the Employment Network

At your first formal appointment with the EN you’ve chosen, remember to take your ticket with you—they’re serious about treating these things like actual tickets. Also expect to be asked a number of questions about your disability, your work history and other subjects. Although the EN may already have received information about you from the SSA, these questions are necessary so the EN can consider whether and how it can help you. Feel free to ask any questions of the EN about its role in assisting you to reach your employment goal.

After you’ve met with an EN staff person, the two of you will develop and sign an Individual Work Plan (IWP). The SSA regulations require that your completed IWP include statements of:

- your vocational goal, including goals for earnings and job advancement
- the services and support you need to achieve your vocational goal
- any terms and conditions related to the provision of these services and supports
- the EN’s acknowledgment that it cannot receive any compensation directly from you for the cost of services and support
- the conditions under which the EN can modify your IWP or terminate its relationship with you
- your rights under the Ticket to Work Program, including your right to take back your ticket if at any time you are dissatisfied with the EN
- the remedies available to you, including the availability of the state protection and advocacy system for the resolution of disputes
- your right to amend your IWP, if the EN is also in agreement
- your right to privacy and confidentiality, and
- your right to have a copy of your IWP, in an accessible format chosen by you.

You’ll notice that you have a number of important rights under the IWP, including the right to change your plan and the right to move to a different EN. If you do decide to switch ENs, however, make sure to get your ticket back—you’ll need it at the next EN office.

6. How the EN Gets Paid—And How This Affects You

An EN can choose between two primary methods of payment for providing services under the Ticket to Work program:

- the outcome payment system, or
- the outcome milestone system.

Under the outcome payment system, the EN can choose to be paid for each month (up to a maximum of 60 months) during which you don’t collect federal disability benefits because of your work and earnings. By contrast, if the EN selects the outcome-milestone system, it will get paid only when you achieve one or more milestones toward permanent employment, with a limit of 60 months of outcome payments. Overall, the EN stands to make more on you if it chooses the outcome-payment rather than the outcome milestone

system. In special cases, the EN has other payment options, such as to be reimbursed for the exact costs of rehabilitating you.

Why should you care about this? Because it may help explain the EN's behavior and what sort of plan or activities it is steering you toward. However, note that the EN, not you, has the power to choose its payment option. Much more detailed information is available at www.yourtickettowork.com.

You Can Still Receive Vocational Rehab Services Without a Ticket

State vocational rehabilitation (VR) agencies will continue to exist, and you don't need a ticket to use their services. Don't be confused by the fact that they must also participate in the Ticket to Work program. Each state VR agency can decide whether its participation will be as an EN or as a state VR agency. If your agency is functioning as a state VR agency, your plan for returning to work will be called an "individualized plan for employment" (IPE). The IPE has similar requirements as the IWP. To you as a disability beneficiary, whether a VR agency also functions as an EN is probably of little significance.

7. Your Progress Toward Self-Supporting Employment

The purpose of the Ticket to Work program is to provide you with the services and support you need to work—with the ultimate goal of reducing or eliminating your dependence on SSDI or SSI benefits. That means that the SSA will keep an eye on you (through MAXIMUS, the central program manager) to determine whether you are, in fact, making timely progress on your work plan. At a certain point, the SSA will expect you to start working. To better understand what will be required, you need to first understand what the SSA means by timely progress and what it will count as work.

a. Definition of Timely Progress

What is timely progress? In general, the SSA asks you to show an increasing ability, year by year, to work at levels that will reduce or eliminate your dependence on disability benefits. However, the SSA also has a very specific calendar of what it considers timely progress.

The SSA's regulations (20 CFR § 411.180) state that during the first 24 months after you assign your ticket, you must show active participation in your work plan—meaning that you take part in the activities outlined in the plan on a regular basis and in the approximate time frames specified. These activities may include employment, if agreed to in the plan. At the end of this initial period, you must successfully complete a 24-month progress review.

There is one exception that you might need to make use of. During the first 24-month period, you can choose to go on "inactive status." This means that your participation is suspended and you don't need to try to work. You won't be terminated from the program if you've chosen to go inactive, but you will, unlike active participants, be subject to continuing disability reviews (CDRs) (see Subsection 9, below). This could result in your disability benefits being cut or reduced.

After that first 24-month period, you must work for at least three of the next 12 months. The three months do not need to be consecutive. If you work one or more months during your initial 24-month period, and you work at a high enough level of work, each such month of work can be counted toward the three months. Then you must successfully pass another review, 12 months after the first one. This is called your first 12-month progress review.

After these first 36 months have passed, you'll need to start working for at least six months out of every twelve. The six months do not need to be consecutive. You'll receive additional progress reviews every 12 months.

b. Definition of Work

Whether you are said to be working under the Ticket to Work program depends on the type of benefits you are receiving and various other individual factors.

SSDI nonblind beneficiaries. If you are receiving SSDI for something other than blindness, then during your first and second 12-month progress reviews, the SSA will consider you to be working during any month in which your earnings from employment or self-employment are at the SGA level for nonblind beneficiaries.

During your third 12-month progress review period, and during later 12-month progress review periods, the SSA will consider you to be working during any month for which Social Security disability benefits are not payable to you because of your work or earnings.

SSDI blind beneficiaries or beneficiaries in trial work period. If you are receiving SSDI and are blind, or are in a trial work period, then during your first and second 12-month progress reviews, the SSA will consider you to be working during any month in which your earnings are at the SGA level for nonblind beneficiaries if:

- your gross earnings from employment are at the SGA level for nonblind beneficiaries, before deductions for impairment-related work expenses, or
- your net earnings from self-employment are at the SGA level for nonblind beneficiaries, before deductions for impairment-related work expenses.

During your third 12-month progress review period, and during later 12-month progress review periods, the SSA will consider you to be working during any month for which SSDI is not payable to you because of your work or earnings.

SSI beneficiaries. If you receive SSI, then during your first and second 12-month progress reviews, the SSA will consider you to be working during any month in which:

- your gross earnings from employment are at the SGA level for nonblind beneficiaries, before any SSI income exclusions, or
- your net earnings from self-employment are at the SGA level for nonblind beneficiaries, before any SSI income exclusions.

During your third 12-month progress review period, and during later 12-month progress review periods, the SSA will consider you to be working during any month in which your earnings from employment or self-employment are sufficient to preclude the payment of SSI cash benefits for one month.

Concurrent SSDI and SSI nonblind beneficiaries. If you are receiving SSDI and SSI at the same time for something other than blindness, then during your first and second 12-month progress reviews, you will be considered working during any month in which your earnings from employment or self-employment are at the SGA level for nonblind beneficiaries.

Concurrent SSDI and SSI blind beneficiaries or beneficiaries in trial work period. If you are receiving SSDI and SSI concurrently and are blind or are in a trial work period, then during your first and second 12-month progress reviews, you will be considered working during any month in which your:

- gross earnings from employment, before any SSI income exclusions or deductions for impairment-related work expenses, are at the SGA level for nonblind beneficiaries, or
- net earnings from self-employment, before any SSI income exclusions or deductions for impairment-related work expenses, are at the SGA level for nonblind beneficiaries.

During your third 12-month progress review period, and during later 12-month progress review periods, the SSA will consider you to be working during any month in which your earnings from employment or self-employment are enough so that you don't need SSDI or SSI cash benefits for the month.

c. If You Fail to Make Timely Progress

If, after reviewing your EN or state VR agency reports, the Program Manager (MAXIMUS) decides that you are not making timely progress toward self-supporting employment, it will conclude that you are no longer using your Ticket. MAXIMUS will deactivate your ticket and you will once again be subject to continuing disability reviews (CDRs).

Nevertheless, you can reenter the Ticket to Work program under certain conditions, depending on how far you had gotten in your work plan when the failure

occurred. The various reinstatement rules are discussed below. For further help in understanding how these rules apply in your case, contact your EN or the Program Manager.

i. Reinstatement During First 24-Month Period

If you failed to make timely progress during the initial 24-month period, no matter what the reason, you can be reinstated by showing three consecutive months of active participation in your work plan. The Program Manager will be responsible for sending you a notice of reinstatement. After reinstatement, your next review would be the 24-month progress review.

ii. Reinstatement After Initial 24-Month Review

If, at the time of your initial 24-month review, the Program Manager decides that you have failed to make timely progress, the rules for reinstatement are somewhat complex. To be reinstated, you'll need to work for three months after the Program Manager's decision, and to work at the SGA level. You'll also need to satisfy the timely progress guideline requirements of the second 12-month progress review, as they pertain to anticipated work levels for the next progress review period. This means that you must expect to be able to work six months out of a 12-month period at the SGA level for nonblind beneficiaries. The reinstatement will be effective on the date the Program Manager sends you the favorable decision notice. With your reinstatement, your second 12-month progress review period will begin.

iii. Reinstatement After First 12-Month Review

If, at the time of your first 12-month review, the Program Manager decides that you have failed to make timely progress, your reinstatement will depend on your working for a subsequent three months at the SGA level. You must also satisfy the timely progress guideline requirements of the second 12-month progress review as they pertain to anticipated work levels for the next progress review period. This means that you must expect to be able to work for six months out of a 12-month period at the SGA for nonblind beneficiaries. The reinstatement will be effective on the date the Program Manager sends you the favorable decision notice.

After reinstatement, your second 12-month progress review period will begin. Then you will be required to work at least six months at the SGA level for nonblind beneficiaries. At your 12-month progress review, the Program Manager will determine whether you have met this requirement. If so, you'll go back to a normal schedule—and the Program Manager will conduct 12-month progress reviews in the usual manner.

iv. Reinstatement After Second 12-Month Review

If, at the end of your second 12-month review period, the Program Manager decides that you failed to make timely progress, you can be reinstated by completing six months of work at the SGA level within the next 12-month period. You must also meet the requirements for timely progress for the next 12-month progress review (Anticipated Work Level) by showing that you can expect to work at the required levels for the third 12-month progress review period (six out of 12 months, with earnings sufficient to preclude payment of SSDI or SSI cash benefits).

After you are reinstated, your third 12-month progress review period will begin. During this 12-month period you will be required to work at least six months with earnings high enough that you don't need cash benefits. At your review, the Program Manager will determine if you have met this requirement. After this, the Program Manager will conduct 12-month progress reviews in the usual manner.

v. Reinstatement After Third 12-Month Review or Later

If, after any progress review beyond your second one, the Program Manager decides that you have failed to make timely progress, you may be reinstated by completing six months of work within the next 12-month period. Your earnings during those six months will need to be high enough to preclude payment to you of SSDI or SSI cash benefits.

You must also satisfy the "Anticipated Work Level" requirement, by showing that you can expect to meet the work level requirements for the next 12-month progress review period—again, six out of the 12 months with earnings sufficient to preclude payment of cash benefits.

After you are reinstated, your next 12-month progress review will begin. At the end of this period

the Program Manager will determine whether you met the work level and other requirements. After this review, the Program Manager will conduct 12-month progress reviews in the usual manner.

d. Reinstatement Procedures and Appeals

When you have satisfied the requirements for reinstatement, you'll need to submit a written request to the Program Manager. If you are approved, you will receive a written decision reinstating you to "in-use status" for your Ticket to Work. If the Program Manager denies your request, you can appeal to the SSA within 30 days. (You'll receive instructions with the denial letter.) If the SSA agrees with you, then the SSA will send you a notice and inform the Program Manager. In that event, you will be reinstated as of the date of the SSA's decision.

8. Dissatisfaction With Your Employment Network

The transition from receiving disability benefits to supporting yourself through employment is bound to involve difficulties and frustrations—it's no easy task. With any luck, you'll receive the assistance you need from the EN, but it's quite possible that the EN will itself be a cause of your frustration, through errors, decisions you don't agree with or bureaucratic hassles.

a. Internal Grievance Procedures

There are several internal steps you can take if you are having a problem with your employment network. First, your EN is required to have a process allowing unhappy clients to voice their dissatisfaction and receive a reply. If this process is not successful, you can call the Program Manager (MAXIMUS) and ask it to resolve your grievance informally. If MAXIMUS cannot help, it will pass the matter on to the SSA.

You also can request an agency in the Protection and Advocacy System in your state to help you if you are unhappy with an employment network. You can ask your state agency to help you at any stage of the grievance process.

If your EN happens to be a state vocational rehabilitation agency, the agency must give you a description of the services available through the Client Assistance Program. It also must give you the opportunity to resolve your grievance through mediation or an impartial hearing.



Remember, you don't have to stay with your EN.

You can take your ticket out of assignment with any EN (including a state vocational rehab agency) for any reason. However, be sure to notify MAXIMUS, so that it can update the SSA database to show that your ticket is no longer assigned.

b. For Outside Help: Your State Protection and Advocacy System

In every state, various organizations have been designated to help you navigate the Ticket to Work system. Collectively, they are referred to as the State Protection and Advocacy System, but the particular organization you contact will no doubt go by a different name. See the state-by-state list of organizations in Appendix E. Or, for more information about this program, call MAXIMUS toll-free at 866-968-7842 (TTY 866-833-2967).

Your State Protection and Advocacy agency can give you help and personal representation on matters like:

- information and advice about vocational rehabilitation and employment services
- specific advice about selecting an EN
- information about special rules called, "work incentives" that are designed to support your efforts to work
- assistance in resolving any complaints against your EN or other associated provider, and
- assistance with any problems that arise with the work plan you develop with your EN.

The Protection and Advocacy agencies are mainly concerned with advocacy and advice about work incentives, rehabilitation opportunities and dispute resolution from a legal perspective. For example, you might wish to dispute the legality of an EN terminating your Ticket to Work for reasons you think are unfair. In that event, you would contact the appropriate Protection and Advocacy agency in your state. Or,

you might just have a question about the difference in the way the SSA evaluates income earned under the Ticket to Work program compared to when it's earned by a person not in the program.

c. Help From the Benefits Planning, Assistance and Outreach Program

Social Security has a new program, called the Benefits Planning, Assistance and Outreach Program (BPAO), which can help you answer questions about SSA's work incentives and decide whether you're ready to start working. It's run through local community organizations, which are paid by the SSA. Each agency will have benefits specialists on its staff. The specialists should be able to deal with complex issues such as how working will affect your benefits payments and what additional federal, state and local supports are available to help you in your effort to work.

In contrast to the legal guidance and advocacy offered by a Protection and Advocacy agency, the major purpose of a BPAO is to provide planning information and assistance regarding work incentives that may be appropriate for you personally. For example, you might want expert advice on the kind of rehabilitation and work goals that would most appropriate in view of the impairments and limitations that you have. See Appendix D for a list of BPAO organizations and their contact information. Or, for more information about this program, call MAXIMUS toll-free at 866-968-7842 (TTY 866-833-2967)

9. Working Shouldn't Affect Your Disability Finding

Ordinarily, the SSA would review your case from time to time to see if you are still disabled—and would stop your benefits if it thought you could work. However, if you choose to participate in the Ticket Program, the SSA will not conduct its usual medical reviews, which should protect you from any suspicion or finding that you're no longer disabled.

To avoid these medical reviews, however, you must be actively using your ticket—that is, engaging in activities outlined in your employment plan on a regular

basis and in the approximate time frames set forth in the plan.

10. Advising the SSA When You Go Back to Work

If you go back to work, or you begin to earn more money, you must notify your local Social Security office. The Ticket Program does not replace the special rules, called “work incentives,” that help serve as a bridge between Social Security and SSI disability benefits and financial independence. These work incentives include:

- cash benefits while you work
- Medicare or Medicaid while you work, and
- help with any extra work expenses you may have as a result of your disability.

(See Section D of this chapter for more information about work incentives.)

11. When Your Ticket Can Be Terminated

You've already read about one of the reasons that your participation in the Ticket to Work program can be cancelled, namely your inability to make timely progress on your work plan (Subsection 7, above). However, the SSA has set forth a number of other bases on which it can stop your participation (or, in their language, “terminate your ticket.”) These are summarized below; to read the list in full, see 20 CFR § 411.155.

a. Ticket Termination For Reasons Other Than Work or Earnings

Your ticket can be terminated for any of the following reasons, and as early as the first month involving one of these reasons:

- Your entitlement to SSDI benefits based on disability has ended for reasons other than your work activity or earnings (such as death, reaching retirement age or medical improvement); or your eligibility for benefits under SSI based on disability or blindness has ended for reasons

other than your work activity or earnings (such as death, reaching retirement age, medical improvement or excess resources), whichever happens later. Note that although the SSA will not review your condition for medical improvement while in the Ticket Program, you might declare your own improvement to SSA and return to regular work. That is why medical improvement is mentioned here as a possible reason for ticket termination.

- If, while you are entitled to widow's or widower's insurance benefits based on disability, you reach age 65.
- If, while you are eligible for benefits under SSI based on disability or blindness, you reached age 65 the month before.

b. Ticket Termination Because of Work or Earnings

Your ticket can also be terminated for reasons having to do with your work and earnings. Remember that the purpose of the program is help you return to work full time. When you have successfully completed the Ticket to Work Program, subject to the work incentives discussed in Section D, you will be performing SGA and your disability benefits will cease. This is the type of ticket termination you are hoping to achieve if you are in the program.

The relationship of your work and income to your receipt of benefits can be difficult to puzzle out, so if you have any questions, the Protection and Advocacy agencies and BPAO agencies are there to help. The SSA Field Offices can also help you clear up any questions. There is plenty of expert advice available—all you have to do is ask.

Summary of Ticket to Work Program

Here's a summary of the important features of the Ticket to Work Program:

- The program is designed to help both SSDI and SSI Social Security disability beneficiaries make a transition to work.
- The Ticket Program is entirely voluntary, and you can stop at will. There is no expense to you.
- An employment network of your choosing will help you develop an individual employment plan and your progress will be evaluated on a regular basis.
- While participating in the Ticket Program, you will not be subject to continuing disability reviews (CDR) for purposes of determining whether your medical condition has improved. Nor will your earnings trigger a CDR—even if they're over the SGA maximum.
- Free legal assistance will be available to you through a Protection and Advocacy agency for disputes or other legal questions you may have with your employment network (Appendix E).
- Free planning and knowledge assistance regarding rehabilitation and vocational alternatives will be available to you through the Benefits Planning, Assistance and Outreach Program (BPAO) agencies available in each state (Appendix D).
- Participation in or successful completion of the Ticket Program and return to full-time work does not eliminate your entitlement to work incentive provisions as discussed in Sections D1 or D2. For example, you will still have prolonged access to Medicare or Medicaid health care coverage and other privileges even when you return to full-time work.

G. The Ticket to Hire Program

The SSA has begun a national referral service to assist employers in hiring motivated, qualified workers with disabilities from the Ticket to Work Program. The Ticket to Hire system works like this:

1. An employer contacts Ticket to Hire and provides information on a job vacancy.
2. The SSA contacts the employment networks (ENs) and state vocational rehabilitation agencies (SVRAs) that service the employer's local area to ask which ones have one or more qualified candidates for the position.
3. Ticket to Hire then gives the employer a referral list of the ENs and SVRAs with candidates and states how many qualified candidates each one can offer.
4. Any follow up is in the hands of the employer—the employer's identity is not given out to anyone.

If you have the skills needed by an employer, your EN or SVRA will enter your name into this program—you don't have to contact Ticket to Hire directly. And your EN will give you ongoing support after you are hired to ensure your success. You can discuss the specific nature of this support with your EN while you're being considered for the job. The discussion will focus on the nature and severity of your impairments. For example, do you need special transportation to get to work? A prosthesis? Everyone's case is different. But don't be shy about asserting your needs. They'll lead to your success later—and bear in mind that the employer isn't suffering by hiring you. The

employer gains various advantages through hiring you via referral from an EN or SVRA, such as tax credits, shortened employee recruiting time and decreased cost of health insurance since you will have extended Medicaid or Medicare coverage for many years, even after your disability benefits stop.



Several SSA publications augment the information in this chapter. They include the following:

- *Social Security: What You Need to Know When You Get Disability Benefits*
- *What You Need to Know When You Get SSI*
- *Working While Disabled: How We Can Help*
- *Working While Disabled: A Guide to Plans For Achieving Self-Support*
- *Your Social Security Payments While You Are Outside the United States*
- *A Pension From Work Not Covered by Social Security*
- *Government Pension Offset*
- *A Guide for Representative Payees*
- *How Social Security Can Help With Vocational Rehabilitation*
- *If You Are Blind: How We Can Help*
- *Medicare Savings for Qualified Beneficiaries*
- *Congress Passes the Ticket to Work and Work Incentives Improvement Act of 1999*, and
- *The Ticket to Work and Self-Sufficiency Program*.

Most of these publications are available on the SSA's website (www.ssa.gov) or by calling 800-772-1213 or 800-325-0778 (TTY). ■

Chapter 14

Continuing Disability Review

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Your case will be reviewed from time to time to see if you still qualify for benefits. If you have experienced significant medical improvement and are capable of working you may lose your benefits. This review process is called *continuing disability review* (CDR). If you receive benefits for many years, expect to go through many CDRs. (See Section A, below, for more on how often reviews are performed.) When it is time for your CDR, someone from your Social Security office will contact you to explain the process and your appeal rights (see Section B, below).

The CDR process is complex, and improperly trained reviewers are prone to making errors. So be sure to study this chapter closely before you undergo a CDR.

CDRs are initially done by a team from the Disability Determination Services (DDS)—the state agency that reviews files for the SSA—including a disability examiner and a doctor, known as a medical consultant (MC). First they review your file; next they will ask you to provide information about any medical treatment you've received and any work you've done; then the DDS team will gather information about you. They will ask your doctors, hospitals and clinics for reports about your health, including the results of medical tests and the medical treatments you have received and how your health problems limit your activities.

The DDS is concerned not only with improvements since your last review or initial disability award, but also with any new health problems. If the DDS medical consultant needs more medical information, you might be asked to undergo a special examination or test, a consultative examination, paid for by the SSA. If your health has improved, the DDS will want to know if you can work. The CDR evaluation measures whether your overall health affects the kind of work you can do—both the work you did in the past and any other kind of work. (See Chapters 8 and 9 for the elements considered in evaluating your ability to work.) If you are appealing a CDR claim, whoever is hearing the appeal—whether an administrative law judge or federal court judge—should still obey the CDR principles set forth in this chapter. (See Chapter 12 for a comprehensive discussion of the appeals process.)

Child CDRs are evaluated in essentially the same way as CDRs for adults. The minor differences are covered in Section D, below.

A. Frequency of Reviews

How often your case is reviewed depends on the severity of your condition and the likelihood of improvement. The frequency can range from six months to seven years. The Certificate of Award of benefits you received when the SSA approved your claim shows when you can expect your first review. Exactly when that review will occur, and the times of subsequent reviews, is left to the judgment of the SSA, depending on which of the following categories you fall into:

Medical improvement expected (MIE). If, when your benefits first start, the SSA expects your medical condition to improve, your first review is likely to be six to 18 months later. Your age can affect whether you will be put into this category. If you will be at least 54½ years old at the scheduled review date, the SSA will generally not use this category unless either of the following is true:

- You have an impairment that is almost certain to result in great improvement, or even full recovery, such as sprains and fractures, as well as cancers with a high cure rate like certain lymphomas and types of leukemia. You could get an MIE review up to age 59½.
- You receive SSI, are legally blind but are expected to improve. You could get an MIE review up to age 64½.

EXAMPLE: Betty was in an automobile wreck and suffered severe fractures in her leg and arm, along with other injuries. Six months after her injury, her fractures had not healed properly and she developed an infection in her bone. She cannot walk without help. Her orthopedic surgeon plans several more operations to restore function and predicts that she will need at least six more months to heal. Because of the high probability that she will improve, the SSA would schedule a CDR as soon as six months after she was granted benefits.

Medical improvement possible (MIP). If, when your benefits first start, the SSA believes it is possible for your medical condition to improve but the SSA cannot predict when that improvement might happen, your

case will be reviewed about every three years. Examples of disorders in which improvement is possible would be conditions such as increased thyroid gland activity (hyperthyroidism) and inflammatory intestinal diseases like regional enteritis or ulcerative colitis. Your age can affect whether you will be put in this category. If you will be at least 54½ years old at the scheduled review date, the SSA will generally not use this category unless the following is true:

- You have an impairment that is almost certain to result in great improvement, or even full recovery, such as a sprain, fracture or a cancer with a high cure rate like certain lymphomas and types of leukemia. You could get an MIE review up to age 59½.

EXAMPLE 1: For several weeks, Livan was having dull, aching pains in the center of his chest, especially when he exerted himself or got excited. Sometimes, he'd sweat with these pains and even get short of breath. Although they at first lasted only a few minutes after he stopped to rest, they eventually lasted up to ten minutes even when he'd stop walking. Livan ignored the warning signs, and woke up one morning with a smothering chest pain like an elephant on his chest. Livan was rushed to the nearest hospital in the middle of a life-threatening heart attack. Treatment stabilized his condition, but he has severe blockages in multiple major arteries supplying his heart muscle. Despite optimum medical treatment, his heart disease is crippling and his symptoms of chest pain, shortness of breath, weakness and fatigue are so severe that the SSA considers him disabled. Livan has refused heart surgery because he is scared—his uncle died on the operating table during a similar procedure. Livan is relatively young at age 50 and medical improvement with surgery could make a big difference in his ability to work. The SSA knows that medical improvement is possible if Livan has surgery, and that there's a good chance Livan will change his mind about the operation. His case will be reviewed within a few years of his being allowed benefits.

EXAMPLE 2: Sharon has had high blood pressure for years, as well as diabetes. She tried to treat herself with various herbal remedies. Her kidneys were progressively ravaged by disease and complete kidney failure qualified her for disability benefits. The SSA knows that a kidney transplant could result in marked medical improvement, and so her case is put in the MIP category. If, during Sharon's application for benefits, her doctor reported that she was soon going to have a kidney transplant, the SSA might put her in the MIE category.

Medical improvement not expected (MINE). If the SSA does not expect your medical condition to improve, your case will be reviewed about every five to seven years. You are most likely to fall into this category if you will be over 54½ years old when the CDR is scheduled, you already have had several CDRs or you have multiple severe impairments or an irreversible condition with no known treatment. Some disorders that the SSA puts into a MINE category include the following:

- amputation
- ankylosing spondylitis of the spine
- autism
- blindness, such as glaucoma
- cerebral palsy
- chronic myelogenous leukemia
- deafness
- degenerative nervous system diseases
- diabetes mellitus
- diabetic eye disease
- diabetic nerve damage
- Down syndrome
- major mood disorders, such as major depression
- mental disorders caused by organic brain disease
- mental retardation
- multiple sclerosis
- Parkinson's disease
- peripheral vascular disease (arteries or veins)
- polio with permanent residuals
- psychotic mental disorders, such as schizophrenia
- rheumatoid arthritis
- stroke
- traumatic spinal cord or brain injuries.

EXAMPLE 1: Doug is 55 years old, has degenerative arthritis throughout his lower spine and suffers pain and stiffness. Surgery would not relieve his symptoms and other forms of treatment have been only moderately effective. Doug has a limited education and has worked only in jobs lifting and carrying 50 pounds or more. In his condition, he can't lift more than 20 pounds, and he is not qualified for jobs with that kind of light work. He's already had two CDRs and his disability continued. The SSA will put him in the MINE category.

EXAMPLE 2: Sally is 52 years old and was diagnosed with severe depression at age 40. Following an initial recovery, Sally's medical record shows years of only partially successful treatment with a variety of medications and six hospitalizations. She continues to live with her elderly parents, but doesn't help much with chores; she spends much of her day watching television, but has poor recall of the programs. Her parents manage her disability benefits, and she cannot function outside of the protective environment of her parents' home without worsening of her condition. She continues to show serious signs of depression, such as lack of pleasure, weight loss, feelings of hopelessness, poor sleep, lack of general interests and some continuing suicidal thoughts. She has had two CDRs, and is seen weekly at a community mental health center with only marginal improvement.

Don't be surprised if you are not notified for a CDR when you are expecting it, based on the MIE, MIP or MINE time limits. When the SSA runs short of operating money, it typically stops performing CDRs rather than cut back on vital operations. The result is that your CDR might come later than would otherwise be the case—sometimes years later.

B. How the SSA Contacts You

A CDR begins when you receive a notice stating that the SSA is reviewing your disability claim. The important thing is to remain calm, understand that this is a regular part of the process and know that you have

not been singled out. Don't assume that you will be automatically terminated from the program. A sample CDR notice is below.

1. Form SSA-455: Disability Update Report

Accompanying the CDR notice will be Form SSA-455: Disability Update Report. A sample copy of the form and instructions on how to complete it follow.



You must use forms provided by the SSA. You can obtain them at your local SSA Field Office or by calling the SSA hotline at 800-772-1213, Monday through Friday (except holidays), from 7 a.m. to 7 p.m. If you are deaf or hard of hearing, TTY service representatives are available at the same times at 800-325-0778. You can also download many necessary forms from the Social Security Administration website at www.ssa.gov.

- ❶ If you've been self-employed (earned income that does not result from being an employee of someone else) within the last two years, check "yes" and indicate the dates you worked and your monthly earnings. Otherwise, check "no."
- ❷ Indicate if you think your condition is better, the same or worse than when you started receiving benefits or at the time of your previous CDR.
- ❸ If your doctor told you during the last two years that you could return to work, check "yes." Otherwise, check "no."
- ❹ If you attended any school or work training program during the last two years, check "yes." Otherwise, check "no."
- ❺ If you are interested in receiving rehabilitation or other services that could help you get back to work, check "yes." Otherwise, check "no."
- ❻ If you have been hospitalized or had any surgery during the last two years, check "yes" and give the reasons for the hospitalization or surgery and the dates. Otherwise, check "no."
- ❼ If you have visited a doctor or clinic for your condition during the last two years, check "yes" and

Sample Notice of Continuing Disability Review (Page 1)

Office of Disability Operations
1500 Woodlawn Drive
Baltimore, Maryland 21241

Date: June 14, 20xx

Claim Number: 000-00-0000

We must regularly review the cases of people getting disability benefits to make sure they are still disabled under our rules. It is time for us to review your case. This letter explains how we plan to start our review of your case.

What You Should Do

Please complete the form enclosed with this letter. Answer all the questions on the form because they are very important. They ask about your health problems and any work you did within the last 2 years.

We have enclosed an envelope for you to use. If there is no envelope with this letter, please send the signed form to us at the address shown above.

If We Do Not Hear From You

You should return the form within 10 days after you receive it. If we do not hear from you in that time, we will contact you again.

If you don't give us the information we need or tell us why you cannot give us the information, we may stop your benefits. Before we stop your benefits, we will send you another letter to tell you what we plan to do.

When We Receive the Completed Form

- If we need more information we will call you. If you do not have a telephone, please give a number where we can leave a message for you.
- The information you give us now will help us decide when we should do a full medical review of your case. We will let you know within 90 days after we receive the completed form whether or not we need to do a full medical review now.

Important Information

If we decide to do a full medical review of your case:

- You can give us any information which you believe shows that you are still disabled, such as medical reports and letters from your doctors about your health.
- We will look at all the information in your case, including the new information you give us.
- We may find that you are no longer disabled under our rules and your payments will stop. If this happens you can appeal our decision. You can also ask us to continue to pay benefits while you appeal.

Sample Notice of Continuing Disability Review (Page 2)**Things to Remember**

Do you want to work but worry about losing your payments or Medicare before you can support yourself? We want to help you go to work when you are ready. But, work and earnings can affect your benefits. Your local Social Security office can tell you more about how work and earnings can affect your benefits.

If You Have Any Questions

If you have any questions, you may call us at 800-772-1213, or call your Social Security Office at 000-000-0000. We can answer most questions over the phone. You can also write or visit any Social Security office. The office that serves your area is located at:

12345 Main Street
New York, NY 10000

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you should call ahead to make an appointment. This will help us serve you more quickly.

Janice L. Warden

Janice L. Warden

Deputy Commissioner for Operations

Enclosures:

SSA-455

Return Envelope

Form SSA-455: Sample Disability Update Report (Page 1)

FORM APPROVED
OMB NO. 0960-0511**DISABILITY UPDATE REPORT**

PRIVACY ACT PAPERWORK ACT NOTICE: The information requested on this form is authorized by the Social Security Act, Sections 205 (a) and 1631 (c) (1) (A) and (B), and regulations at 20 CFR 404.1589 and 416.889. The information provided will be used to further document your claim and permit a determination about your continuing disability. Information requested on this form is voluntary. However, if you do not provide the required information, a decision based on the evidence in your file can result in a determination that your period of disability is ceased. While the information you furnish on this form would almost never be used for any purpose than in making a determination about your disability, such information may be disclosed by SSA for the following purposes: (1) To assist SSA in determining the right to Social Security benefits for yourself or another person, (2) To facilitate statistical research and audit activities necessary to assure the integrity and improvement of programs administered by the Social Security Administration and another agency. Explanations about these and other reasons why information you provide us may be used or given out are available in the Social Security offices. If you want to learn more about this, contact any Social Security office.

TIME IT TAKES TO COMPLETE THIS FORM

We estimate that it will take you about 15 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, or on any other aspect of this form, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD, 21235-0001, and to the Office of Management and Budget, Paperwork Reduction Project (0960-0511), Washington, D.C. 20503. Send only comments relating to our estimate or other aspects of this form to the offices listed above. All requests for Social Security cards and other claims related information should be sent to your local Social Security office whose address is listed in your telephone directory under the Department of Health and Human Services.

Name and Address

Claim Number

John Smith
123 4th St.
Baltimore, MD 21241

000-00-0000

1. Within the last 2 years have you worked for someone or been self-employed?

①

Yes ____ No ☒If yes, please complete the information below.

Work Began (month/year)	Work Ended (month/year)	Monthly Earnings
1. ____/____	____/____	\$ ____
2. ____/____	____/____	\$ ____
3. ____/____	____/____	\$ ____

2. Check the block which best describes your health within the last 2 years:

②

Better ____ Same ____ Worse ☒

3. Within the last 2 years has your doctor told you that you can return to work?

③

Yes ____ No ☒

Form SSA-455: Sample Disability Update Report (Page 2)

4. Within the last 2 years have you attended any school or work training programs?

④

Yes ____ No ☒

5. Would you be interested in receiving rehabilitation or other services that could help you get back to work?

⑤

Yes ☒ No ____

6. Within the last 2 years have you been hospitalized or had any surgery?

⑥

Yes ☒ No ____

If yes, please list below:

Reason

Date: (month/year)

- | | |
|-----------------------|------------------|
| 1. <u>Lung Cancer</u> | <u>5/21/200X</u> |
| 2. _____ | _____ |
| 3. _____ | _____ |

7. Within the last 2 years have you gone to a doctor or clinic for your condition?

⑦

Yes ☒ No ____

If yes, show the date and the reason for the visit.

- | | |
|---|-------|
| 1. Date <u>12/11/200X</u> | |
| Reason <u>problem breathing</u> | _____ |
| 2. Date <u>3/22/200X</u> | |
| Reason <u>x-ray and biopsy of possible cancer</u> | _____ |
| 3. Date <u>5/10/200X</u> | |
| Reason <u>pre-operative meeting and tests</u> | _____ |

I know that anyone who makes a false statement or representation of material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law. I affirm that the above statements are true.

SIGN J. Smith

Date 7/1/200X

Telephone
Number

HERE □

555-555-4444

give the reasons for the visits and the dates. Otherwise, check “no.”

Then date and sign the form, and add your telephone number, if any. Return the form to the SSA in the envelope provided.

Once the SSA Field Office receives your Form SSA-455, the SSA will decide whether your benefits should simply continue—in which case the CDR process ends—or whether a full medical review of your claim is necessary. You have no other participation in this screening procedure. In either event, you will be notified in writing by another notice.

2. Form SSA-454-BK: Report of Continuing Disability Interview

If the SSA chooses a full CDR, you will be sent SSA-454-BK: Report of Continuing Disability Interview to complete. (You can also obtain this form anytime you want simply by calling the SSA and asking for it.) Along with the form will be a notice inviting you to contact a Social Security representative at your local Field Office. Such contact is meant to protect your rights and assure that you fully understand the questions on the form. It will also give you the opportunity to ask questions that you might have about your CDR. You can complete the form and mail it back to your local Field Office. The SSA prefers face-to-face contact, but you can do it by telephone if you wish. It is also possible for you to waive personal contact under certain conditions:

- the relationship between you and your representative payee is an official one (for example, an institution, government agency)
- you or your representative payee agrees or requests that the CDR be conducted by mail
- contact must be made, but is not practical at the present time (for example, because of weather or travel considerations) and you or your representative payee agrees to waive the personal contact and have the CDR conducted by mail instead, or
- you reside in a foreign country, unless you are in a U.S. District Office.

Form SSA-454-BK is 11 pages long, but filling it out is more time-consuming than difficult. In addition to

the help available at the SSA Field Office, an attorney or other representative can fill out much of the form for you. A copy of the form and instructions on how to complete it follow. For all questions, the SSA wants to know what has happened since the time you filed your original disability application or had your last CDR.

Don't worry about the little code boxes asking for the Types of Entitlement. The SSA Field Office representative can complete that information. If the beneficiary is not doing the reporting, note the name, address and relationship of the other person reporting. This other person would be someone like a guardian or representative. Also state why the beneficiary is not reporting.

① a. Describe in your own words the disabling conditions for which you receive benefits. *Don't* list new impairments that have appeared since you were granted benefits or since your last CDR.

b. If your disabling impairment has changed in severity, check Yes and describe the changes. Otherwise, check No.

c. If you have new impairments, check Yes and describe the new conditions. Otherwise, check No.

② a. If you feel you can return to work, check Yes. Then turn to page 6, Item 14, and explain why you think you can work and any limitations on your work. If you don't think you can work, check No and turn to Item 14 and explain why you can't work. Try to be specific and concise in your explanation, and stick to the important points.

EXAMPLE 1: Pete was considered disabled because of heart disease and arthritis. He checked No and wrote in Item 14 the following: “My doctor says the blockages in my heart arteries are still there. I have just as many chest pains—on average, twice a day—as I had the last time my claim was reviewed. I still get chest pain walking a half-block slowly on level ground and sometimes I am short of breath. I have not had heart surgery and must take the same amount of medications. I've had no surgery for the arthritis in my knees; if anything, I can't stand as long as before. I have to sit down because of knee pain after standing more than about 30 minutes. My ability to do daily activities

Form SSA-454-BK: Sample Report of Continuing Disability Interview (Page 1)

SOCIAL SECURITY ADMINISTRATION		Form Approved OMB No. 0960-0072	
REPORT OF CONTINUING DISABILITY INTERVIEW (Write Legibly)		OFFICE 9999	DATE 7-25-2003
		REPORT MADE ☐ IN PERSON ☒ TELEPHONE	PLACE OF REPORT ☐ DO ☐ CONTACT STATION ☒ HOME ☐ OTHER
SOCIAL SECURITY NUMBER 111-11-1111	WAGE EARNER James Chang	BENEFICIARY'S NAME IF NOT WAGE EARNER	
PERSON REPORTING ☒ BENEFICIARY ☐ OTHER PERSON (Show name, address, relationship, and why beneficiary is not reporting.)			
NAME AND RELATIONSHIP		ADDRESS	WHY BENEFICIARY IS NOT REPORTING
TYPE(S) OF ENTITLEMENT (Check all that apply.)	TITLE II TITLE XVI	☒ DIB ☐ FZ ☐ DWB ☐ CDB ☐ ESRD ☐ HIB ☐ DI ☐ DS ☐ DC ☐ BI ☐ BS ☐ BC	
PRIVACY ACT/PAPERWORK ACT NOTICE: The information requested on this form is authorized by the Social Security Act, Sections 205(a) and 1631(e)(A) and (B), and Title 20 CFR 404.1589 and 416.989. The information provided will be used to further document your claim and permit a determination about your continuing disability. Information requested on this form is voluntary. However, if you do not provide the required information, a decision based on the evidence in your file can result in a determination that your period of disability is ceased. While the information you furnish on this form would almost never be used for any purpose other than making a determination about your disability, such information may be disclosed by SSA for the following purposes: (1) To assist SSA in determining the right to Social Security benefits for yourself or another person; (2) To facilitate statistical research and audit activities necessary to assure the integrity and improvement of programs administered by the Social Security Administration, and (3) to comply with laws and regulations requiring the exchange of information between the Social Security Administration and another agency. These and other reasons why information about you may be used or given out are explained in the Federal Register. If you would like more information about this, get in touch with any Social Security office.			
Please use this form to describe your disabling condition since (date disability began or, if later, date of prior investigation.)		DATE 10-3-98	
NOTE: All information (except Part II) must reflect the beneficiary's (or his/her representative's) statements regarding the disabling condition since the last interview, i.e., the initial disability application or continuing disability investigation. This report will be one of the criteria in verifying continuing eligibility to disability benefits. If, after completion of the investigation, it is determined that there no longer is a disabling condition, benefits will be terminated.			
PART I INFORMATION ABOUT YOUR CONDITION			
1. a. What is the disabling condition(s) for which you are receiving disability benefits? 1 Heart disease—coronary arteries blocked. I had bypass surgery in 1999. I also had emphysema and bronchitis.			
b. Has there been any change (for better or worse) in your disabling condition since you last reported such information to us? ☒ Yes (If "yes", describe any changes below.) ☐ No My chest pain got better after heart surgery, but my shortness of breath is worse.			
c. Do you have any new injuries or illnesses? ☒ Yes (If "yes", describe below.) ☐ No My hearing is worse, and I've developed arthritis in my back.			
2. a. Do you feel you are able to return to work? 2 ☐ Yes (If "yes", explain and describe any limitations in Part VI.) ☒ No (If "no", explain in Part VI how your injuries or illness prevent you from working.)			
b. Has your doctor told you that you are able to return to work? ☐ Yes (If "yes", answer items c, d and e.) ☒ No ☐ Did not say			
Form SSA-454-BK (4-93)		1. (OVER)	

Form SSA-454-BK: Sample Report of Continuing Disability Interview (Page 2)

2.	c. List the name and address of the doctor(s) who told you to return to work.		
continued	NAME NA		
	ADDRESS 		
	d. What date did your doctor tell you that you could return to work? (mo., day, yr.) NA	e. Did the doctor restrict you to limited or part-time work? ☐ Yes (If "yes", explain in Part VI.) ☐ No	
PART II — INFORMATION ABOUT YOUR MEDICAL RECORDS			
NOTE: When completing Part II, provide a summary of all medical examinations and treatments which you have received in the last 12 months.			
3.	List the name, address and telephone number of the doctor who has your latest medical records.		If you have not seen a doctor, check here ☐
3	NAME Dr. Stanley Crowe	ADDRESS 412 11th Street Dallas, TX 93870	
	TELEPHONE NUMBER (Include area code) 214-555-5555		
	How often do you see this doctor? every 6 months	Date you first saw this doctor (mo., day, yr.) 10-3-98	Date you last saw this doctor (mo., day, yr.) 6-12-2003
Reasons for visits (show illness or injury for which you had an examination or treatment) check-ups on my heart			
Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE") Drugs for chest pain. Then bypass surgery when drugs didn't work. Don't need heart drugs now.			
a. Have you seen any other doctors? ☒ Yes (If "yes", show the following.) ☐ No			
	NAME Dr. Glen Rose	ADDRESS The Pulmonary Clinic #82 Oak Cove Dallas, TX 93872	
	TELEPHONE NUMBER (Include area code) 214-555-6666		
	How often do you see this doctor? every 6 months	Date you first saw this doctor (mo., day, yr.) 4-2-96	Date you last saw this doctor (mo., day, yr.) 3-8-2003
Reasons for visits (show illness or injury for which you had an examination or treatment) Check-ups for my emphysema and bronchitis			
Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE") Drugs to help widen my airways—theophylline.			
	NAME Dr. Jane Barr	ADDRESS The Orthopedic Specialists 902 Freeway Drive Dallas, TX 93875	
	TELEPHONE NUMBER (Include area code) 214-555-7777		
	How often do you see this doctor? only saw once	Date you first saw this doctor (mo., day, yr.) 7-1-2003	Date you last saw this doctor (mo., day, yr.) 7-1-2003
Reasons for visits (show illness or injury for which you had an examination or treatment) back pain			
Type of treatment received or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicine show "NONE") Darvocet for pain			

Form SSA-454-BK: Sample Report of Continuing Disability Interview (Page 3)

3. continued	NAME Dr. Holly Sanchez		ADDRESS ENT Specialists, Inc. 434 N. Spruce St. Dallas, TX 93870	
	TELEPHONE NUMBER (Include area code) 214-555-0000			
How often do you see this doctor? twice only		Date you first saw this doctor (mo., day, yr.) 4-3-2003		Date you last saw this doctor (mo., day, yr.) 6-21-2003
Reasons for visits (show illness or injury for which you had an examination or treatment) hearing loss				
Type of treatment or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE") prescribed hearing aids				
4.	Have you been hospitalized or treated at a clinic for your disabling condition?		☒ Yes (If "yes", show the following.) ☐ No	
4	NAME OF HOSPITAL OR CLINIC Dallas General Hospital		ADDRESS 4300 Alameda Blvd. Dallas, TX 93870	
	PATIENT OR CLINIC NUMBER RC-43-112			
	Were you an inpatient (i.e., stayed at least overnight)? ☒ Yes (If "yes", fill in the dates below.) ☐ No		Were you an outpatient? ☐ Yes (If "yes", fill in the dates below.) ☒ No	
	DATES OF ADMISSIONS	DATES OF DISCHARGE	DATES OF VISITS	
	5-1-99	5-12-99		
Reason for hospitalization or clinic visits (show illness or injury for which you had an examination or treatment) Heart evaluation				
Type of treatment or medicine received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE") Heart bypass surgery—no medicine required now.				
NAME OF HOSPITAL OR CLINIC		ADDRESS		
PATIENT OR CLINIC NUMBER				
Were you an inpatient (i.e., stayed at least overnight)? ☐ Yes (If "yes", fill in the dates below.) ☐ No		Were you an outpatient? ☐ Yes (If "yes", fill in the dates below.) ☐ No		
DATES OF ADMISSIONS	DATES OF DISCHARGE	DATES OF VISITS		
Reason for hospitalization or clinic visits (show illness or injury for which you had an examination or treatment)				
Type of treatment or medicines received (such as surgery, chemotherapy, radiation and the medicines you take for your illness or injury, if known. If no treatment or medicines show "NONE")				
If you have seen other doctors or if you have been in other hospitals or clinics for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits in Part VI.				

Form SSA-454-BK: Sample Report of Continuing Disability Interview (Page 4)

5. Have you been seen by other agencies for your injury or illness? (VA, worker's compensation, welfare, etc.) (List any other agencies, their addresses, your claim numbers, dates and treatment received in Part VI.)

☐ Yes (If "yes", fill in the information below.) ☒ No

NAME OF AGENCY

ADDRESS OF AGENCY

YOUR CLAIM NUMBER

DATES OF VISITS (mo., day, yr.)

TYPES OF TREATMENTS OR EXAMINATION RECEIVED

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part VI.

6. Have you had any of the following tests?

TEST	Check appropriate block(s)		IF "YES" SHOW	
	YES	NO	WHERE DONE	WHEN DONE
EKG—Resting	☒	☐		
EKG—Treadmill	☒	☐		
Chest x-ray	☒	☐		
Other x-ray (specify ►) <i>Back</i>	☒	☐	<i>Dr. Barr's office</i>	<i>7-1-2003</i>
Breathing tests	☒	☐	<i>Dr. Rose's office</i>	<i>4-2-97 and 3-8-2003</i>
Blood tests	☒	☐	<i>Dallas General Hosp.</i>	<i>5-1-99</i>
Other (specify ►) <i>Hearing</i>	☒	☐	<i>Dr. Sanchez's office</i>	<i>4-2-2003</i>
Other (specify ►)	☐	☐		
Other (specify ►)	☐	☐		
Other (specify ►)	☐	☐		

PART III — INFORMATION ABOUT YOUR ACTIVITIES

7. Has any doctor told you to cut back or limit your activities in any way since the date shown on Page 1?

☒ Yes (If "yes", give the name of the doctor below and tell what he/she told you about cutting back or limiting your activities.) ☐ No

NAME OF DOCTOR

Dr. Rose, Dr. Barr

EXPLANATION OF WHAT DOCTOR TOLD YOU

Dr. Rose said that I should not let myself over-exert to the point I get severely short of breath. See remarks at 14.

8. In the areas below, describe your daily activities and state what and how much you do of each; how often you do it; and any assistance you require.

8. PERSONAL MOBILITY (walking, moving about, exercising your legs, etc.)

My back gets stiff when I have to sit too long, but if I stand over 30 minutes, it begins to hurt. I can walk about 2 blocks at a normal pace with only some shortness of breath, but if I walk faster or carry something—even 10 lbs—I get short of breath in less than a block.

PERSONAL NEEDS AND GROOMING (dressing, bathing, etc.):

I have no problems in this area, except because of back pain my wife has to help me put on and take off my socks.

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8. continued **HOUSEHOLD MAINTENANCE** (cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):
 I can cook small meals, as long as I don't have to lift heavy pots and skillets. I help my wife dust a little, but the dust makes me cough. I can go shopping, but I have to take it easy and sit down frequently—about every 15–30 minutes.

RECREATIONAL ACTIVITIES AND HOBBIES (TV, radio, newspapers, books, fishing, bowling, musical instruments, etc.):
 I used to love to hunt and fish, but I sure can't do either anymore, unless I just sit and prop up the fishing pole. I still like to read, and can listen to TV with my hearing aids.

SOCIAL CONTACTS (visits with friends, relatives, neighbors, church, social clubs):
 Because of my shortness of breath, most relatives come to see us. I can still go to church, but only for brief services.

OTHER (drive car, motorcycle, ride bus or subway, etc.):
 I can drive OK, except my back starts hurting after about an hour. I can also ride a bus, but the exhaust fumes really make me cough and I can't walk to a bus stop.

9. Have you attended (trade, vocational or academic) school or had any other type of vocational training since you began receiving disability benefits?
9 ☒ Yes (If "yes", explain below.) ☐ No
 If "yes," explain
 I tried to take a course in computer repair by mail, but couldn't finish—I didn't understand it.

10. Are you attending school? ☐ Yes (If "yes", show the following.) ☒ No
10 NAME OF SCHOOL ADDRESS OF SCHOOL
 CURRENT GRADE

PART IV – INFORMATION ABOUT THE WORK YOU DID
 When completing Part IV provide information since date you became disabled.

11. Since you became disabled, have you done any work? ☐ Yes (If "yes", show the following for each work attempt, no matter how short it was.) ☒ No
11

JOB TITLE (Be sure to begin with your usual job)	TYPE OF BUSINESS	DATES WORKED (month/year)		DAYS PER WEEK	RATE OF PAY (per hour, day, week, month or year)
		FROM	TO		

Form SSA-454-BK: Sample Report of Continuing Disability Interview (Page 6)

12. Describe your basic duties (explain what you did and how you did it) below. Also, explain why you stopped working for each work attempt listed in item 11.

12

PART V — INFORMATION ABOUT REHABILITATION SERVICES

13. VOCATIONAL REHABILITATION

13

IMPORTANT: Even if it is determined that you are not disabled you may be eligible for continued payments if you are in an approved vocational rehabilitation program and meet other requirements of the law.

- a. Are you receiving help, such as services, training or counseling from the state vocational rehabilitation agency or other vocational rehabilitation program.
- ☐ Yes (If "yes", complete the following.) ☒ No

- b. What kind of help have you been receiving?

see remarks

- c. Do you expect to receive any type of training?

☐ Yes (If "yes", when? →)

☒ No

When

- d. What is the name, address and phone number of your VR counselor, and the State vocational rehabilitation agency or other vocational rehabilitation service provider?

NAME

ADDRESS

TELEPHONE NO. (Include area code)

PART VI — REMARKS

14. Use this section for additional space to answer any previous questions. Also, use this space to give any additional information that you think will be helpful in the review of the continuing entitlement to Social Security disability benefits. (If you need more space, use a separate sheet of paper. Also, if you wish, you may attach any evidence that shows your current condition.)

14

#7 Dr. Rose said if I over-exerted I could be in danger from my heart not getting enough oxygen, due to my lung disease. He also said I should avoid dust & fumes. (I worked on farms for 25 years and was exposed to dust all the time.) Additionally, he said that because of my advanced heart and lung disease, I should avoid very hot or cold environments.

Dr. Barr said I had severe arthritis in my spine as well as degenerated discs. She said that I should not lift over 20 lbs and that I should avoid excessive bending of my back. She also said I should avoid activities that jar my back, such as riding heavy equipment like tractors.

Dr. Barr said that there was no surgery that could be done on my back.

Form SSA-454-BK: Sample Report of Continuing Disability Interview (Page 7)

14.
continued

Remarks

I tried to get some rehabilitation training, but I was just too short of breath to keep attending courses.

Form SSA-454-BK: Sample Report of Continuing Disability Interview (Page 8)

PART VII – AUTHORIZATION AND NOTIFICATION STATEMENTS

I understand that this report will be used to determine whether to continue or to stop my disability benefits. I also understand that if I am receiving Social Security disability benefits and Supplemental Security Income payments, this questionnaire is applicable to both claims.

- ▶ Copies of medical records may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
- ▶ Results of any such independent examination may be provided to my personal physician.
- ▶ Medical information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service.
- ▶ The State Vocational Rehabilitation Agency may review any medical evidence for determining my eligibility for rehabilitative services.
- ▶ I agree to notify the Social Security Administration if my medical condition improves or I go to work.
- ▶ I know that anyone who makes a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law. I affirm that the above statements are true.

SIGNATURE OF CLAIMANT OR PERSON FILING
ON THE CLAIMANT'S BEHALF

James Chang

DATE (Mo., Day, Yr.)

7-25-2003

TELEPHONE NUMBER (Include
area code)

214-222-2222

MAILING ADDRESS (Number and Street, Apt. No., P.O. Box or Rural Route)

124 Pleasant Oaks

CITY AND STATE

Dallas, TX

ZIP CODE

93760

NAME OF COUNTY (In which
you now live)

Dallas

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X) two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

1. SIGNATURE OF WITNESS

2. SIGNATURE OF WITNESS

ADDRESS (Number & street, city, state and zip code)

ADDRESS (Number & street, city, state and zip code)

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

TIME IT TAKES TO COMPLETE THIS FORM

We estimate that it will take you about 30 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235-0001. **Send only comments relating to our "time it takes" estimate to the office listed above. All requests for Social Security cards and other claims-related information should be sent to your local Social Security office, whose address is listed under Social Security Administration in the U.S. Government section of your telephone directory.**

Form SSA-454-BK: Sample Report of Continuing Disability Interview (Page 9)

PART VIII – FOR SSA USE ONLY – DO NOT WRITE BELOW THIS LINE																																																	
NAME OF CLAIMANT		SOCIAL SECURITY NUMBER																																															
James Chang		111-11-1111																																															
15. a. Check each item to indicate if any difficulty was observed:																																																	
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b. If any of the above items were checked "yes", describe the exact difficulty involved.																																																	
Claimant sounded like he was short of breath on the telephone. He also had some difficulty hearing, and some questions had to be repeated. States he has hearing aids in both ears and an amplifier on his telephone. He says he has more difficulty hearing when there is a lot of background noise.																																																	
c. Describe the claimant fully (e.g., general build, height, weight, behavior, any difficulties that add to or supplement those noted above). Indicate any other noticeable physical/mental limitations/impairments. Also, indicate any unusual circumstances surrounding the interview, e.g., how claimant came to the DO/BO for the interview, lack of difficulty where it might be expected.																																																	
Claimant not seen. Telephone interview.																																																	

has not improved—see my statements about my daily activities under Part III.”

EXAMPLE 2: Jack was disabled because of a combination of heart disease and lung disease. He checked Yes and wrote in Item 14: “Last year I had heart surgery to restore the blood flow to my heart. I feel a lot better. My chest pains are gone and I don’t feel nearly as tired as I did before. I still have some shortness of breath from my lung problem, but much less now that I’ve lost weight, stopped smoking and eat right. I’ve been working part time at my old job without difficulty and expect my doctor will clear me to return full-time.”

② b. If your doctor told you that you could return to work, check Yes and turn to page 2. Enter the name and address of the doctor who said you could return to work (2c), when the doctor told you (2d) and whether the doctor said your work should be limited or part-time (2e). If the doctor said you could work on a limited or part-time basis, explain what the doctor said in Item 14 on page 6. If your doctor said you could not return to work, check No on page 1. If your doctor hasn’t said either way, check Did not say.

③ In the first part of Item 3, enter the name, address and phone number of the doctor who has your most recent medical records. Then enter how often you see this doctor, when you first and most recently saw this doctor, the reasons for your visits and the types of treatments or medicines you received. If you are under the care of more than one doctor, check Yes in Item 3a and enter the same information for up to three other doctors. If you are not under the care of more than one doctor, check No in Item 3a.

④ If you have been hospitalized or treated at a clinic for your impairment, check Yes and enter the names and the addresses of the hospitals or clinics, your patient or clinic number (which should be on your medical records or hospital bills), whether or not you were an outpatient, the dates of admission and discharge, the reasons for your hospitalization or clinic visits and the types of treatments or medicines you received. You can enter this information for up to two different hospitals or clinics. If you have not been

hospitalized or treated at a clinic for your impairment, check No.

⑤ If you have been seen by an agency other than the SSA, check Yes and enter the names and the addresses of the agencies, your claim number, the dates of your visits and the types of treatments or examinations you received. If you have been seen by more than one agency, enter additional agencies under Item 14 on page 6. If you have not been seen by an agency other than the SSA, check No.

⑥ If you have undergone any of the listed tests (or others that you can add to the list) check Yes and enter where and when the test was done. You don’t need to know the results of the tests. Check No if you haven’t had the test.

⑦ Part III covers your activities of daily living (ADLs). These are important because they provide real-life examples of your actual functional abilities. In Item 7, check Yes if any doctor has told you to limit your activities. Then enter the name of the doctor and what the doctor told you. The SSA will contact your doctor for verification. If no doctor has told you to limit your activities, check No.

⑧ Item 8 is one of the most important on the form. It is your chance to describe to the SSA in your own words the difficulties you have in performing ADLs. Take your time and write something in every section. Tell the SSA what activity is limited, to what degree that activity is limited and how the limitation is caused by your medical condition. Here are some specific suggestions:

Personal mobility. Write down the specific things you have difficulty doing—such as walking, getting out of a chair or moving about in some other way. Next, describe the symptom or problem that specifically limits you—such as weakness or paralysis, numbness, pain, poor balance, dizziness or lack of coordination. Finally, describe the degree of severity of your symptoms—such as inability to stand for more than 30 minutes because of back pain, inability to walk more than two blocks due to leg pain or shortness of breath.

Personal needs and grooming. Describe any difficulties you have. Don’t underestimate the importance of these everyday activities that many people take for granted.

For example, if you have had a stroke, you may be unable to button your shirt with one hand. Inability to button a shirt or pick up coins tells the SSA that you have difficulty with fine movements of your fingers, movements that are critical in some kinds of work. A claimant with a profound mental disorder, such as severe dementia like Alzheimer's disease, might require help in even basic personal needs. Be sure to note if a caregiver provides help. And if you are completing the form for a recipient with a mental disorder, ask the caregiver for insight into what the recipient can and cannot do.

Household maintenance. The SSA is not so much interested in whether you actually do things around the house—the SSA wants to know if you *can* do these things. For example, the fact that you don't cook is not an argument that you cannot cook. It is more significant that you could previously cook but no longer are able to because you can't stand for very long and your kitchen isn't wheelchair accessible, you can't use your fingers, or you are inattentive and burn food or your anxieties keep you from going out to shop.

With a physical disorder, you might have difficulty standing or using your hands to perform routine household activities—for instance, the pain in your hands is so severe you cannot turn a wrench or hold a paintbrush, or your loss of coordination means you can't hit a nail to do repairs around the house. Maybe you can't vacuum because of shortness of breath.

Whatever the limitation, be specific and give the reason for the limitation. For example, you might write, "I can rake leaves slowly for 30 minutes before I get so exhausted I have to rest for the same length of time."

Recreational activities and hobbies. This information helps the SSA learn important things about your physical and mental abilities. For example, hunting requires a certain amount of physical stamina, but the amount depends on the type of hunting you do. There is a big difference between a hunter who can hunt only by riding down a dirt road on a four-wheeler looking for a deer and one who can walk miles through the woods for hours.

Similarly, the ability to play musical instruments implies an ability to use the fingers in a coordinated way, especially regarding fine movements. Reading newspapers shows the ability to read small print and to concentrate. The lack of interest in various recre-

ational activities can be a sign of depression and withdrawal.

Social contacts. The SSA is looking at your ability to interact with other people. That you don't engage in any of these activities does not necessarily mean you can't. Social skills are important in determining the type of work you can do, especially in evaluating the severity of a mental disorder. What is particularly revealing to the SSA is a change in which social activities previously of interest to you are no longer, and what symptoms you have that prevent your socialization. For example, the SSA will want to know if you previously enjoyed going to church but no longer do because of depression, paranoia or fear of leaving home—but the SSA does not care that you've never been interested in going to church. Social contacts need not be limited solely because of mental disorders. For example, advanced lung disease, muscle weakness or pain can limit your desire and ability to interact socially.

Other. Describe any other problems with ADLs not previously discussed, such as epilepsy that restricts your driving a car, difficulties with balance that prevent you from riding a motorcycle, fear or confusion that prevent you from traveling alone on a bus or subway, or memory problems that keep you from going out alone without getting lost.

- 9 If you have attended school or undergone any other vocational training since your benefits began, check Yes and explain. Otherwise check No.
- 10 If you are currently attending school, check Yes and give the name and address of the school and your grade. Otherwise check No. If you're in school, the SSA will want to see if you are acquiring possible work skills that you did not previously have.
- 11 If you have worked since you became disabled, check Yes. For each job you have held, enter your job title (such as receptionist), the type of business (such as dentist's office), the dates you began and ended each job, how many days a week you worked and the pay you received. List all jobs, no matter how short or low paying. If you haven't worked since you became disabled, check No.
- 12 Describe the basic duties of the jobs listed in Item 11 and explain why you stopped working at each job. For example, you might have tried to do work that

required a lot of bending and lifting, only to find that your back pain worsened and you were unable to do the job. Or perhaps your job took a lot of concentration, but after a stroke you could no longer think clearly enough. Maybe the arthritis in your hips caused you too much pain when you tried to return to your job as a waitress. Or it could be that when you tried to return to your job as a salesman your anxieties became too overwhelming. Be as specific as possible.

13 If you are receiving any type of vocational training, check Yes in Item a and describe the training in item b. If you are not, check No in Item a. If you expect to receive vocational training, check Yes in Item c and give the name, address and phone number of your vocational counselor and the agency in Item d. If you do not expect to receive vocational training, check No in Item a. Increased vocational skills usually translate into an increase in possible jobs you can perform.

14 Use this space (on pages 6 and 7) to continue your answer to any previous question.

Page 8. Sign and date the form and enter your phone number and mailing address. If you can't sign your name—perhaps because you've had a stroke—enter an "X" in the signature space and have two witnesses who know you sign their names and enter their addresses. By signing, you are telling the SSA that you agree to let your medical records be reviewed by the SSA, their doctors, the DDS and perhaps a vocational agency. You also agree to tell the SSA if your medical condition improves or you go to work.

Leave the rest of the form blank. If you went to a Field Office to fill out the form with the help of an SSA representative, that person will enter her impressions of you in Items 15–20. If you filled in the form on your own, mail it back to your SSA Field Office. (Look in the government section of your phone book for the closest field office or check at www.ssa.gov on the Internet.)

C. Medical Improvement Review Standard

The SSA evaluates your case using what it calls Medical Improvement Review Standard (MIRS). The

MIRS governs how the SSA evaluates CDRs. Congress created the MIRS in the early 1980s when many disability recipients claimed that their benefits were being terminated despite the fact that they were still disabled. You need to understand the MIRS because some medical consultants, examiners and others who conduct CDRs are inadequately trained in the MIRS. Someone may incorrectly terminate your benefits. The MIRS isn't applied under certain circumstances (see Section C2).



Insist on a medical review. If the DDS terminates your benefits, ask to review your file. If necessary, insist that a DDS medical consultant review your claim. Otherwise, a disability examiner who is not a doctor may be responsible for stopping your benefits. (See Chapter 6, Section G. Also see Chapter 12 on how to review your file and file an appeal.)

1. MIRS Requirements

Under the MIRS, your CDR will be evaluated quite differently from your original application for disability benefits. During your initial application, the burden of proof to show disability was on you. But in a CDR, the burden shifts to the SSA. This means that your benefits will continue unless the SSA can clearly show that you have improved to the extent you can work. The MIRS requires two different showings before the SSA can terminate your benefits. The SSA must show that:

- you have significant medical improvement related to your ability to work, as determined by a DDS medical consultant (see Subsection a below), and
- you can actually perform substantial gainful activity (as determined by a DDS claims examiner or vocational specialist; see Subsection b below).

a. Medical Improvement Related to Your Ability to Work

Medical improvement means there has been some lessening in the severity of your impairments since

your last CDR. It is important to understand that medical improvement is sometimes only minor. In these instances, it would be unfair for the SSA to say your condition has gotten better in any meaningful sense. (See the example regarding trivial impairments below.) Therefore, federal regulations require that there be *significant* medical improvement.

In most instances, the phrase “related to your ability to work” can be taken to mean “significant medical improvement” and that’s the way it will be used in the following discussion. However, “related to the ability to do work” is important legal language used by the SSA, so you need to know that it exists. For example, if you have a marked improvement in the medical severity of one of your various disorders that has nothing to do with your ability to work (such as a hair transplant or a hysterectomy for uterine fibroids), the SSA should not say you have had significant medical improvement. No matter how much some things improve they have little to do with the ability to work. To exclude impairments that are irrelevant or trivial from application of MIRS is the reason federal regulations use the phrase “related to your ability to work.”

The date that your claim was last reviewed and benefits allowed or continued is called the *comparison point decision* (CPD). Depending on the history of your claim, the CPD could be the date of your initial allowance, the date you were allowed at some appeal level or the date of a previous CDR.

The DDS medical consultant should not be concerned with how or why you were placed on disability or re-approved after your previous CDR or who made the decision, subject to the exceptions discussed in Subsection 2b. The MIRS applies *only* to the medical severity of your impairments at the CPD date as compared to those same impairments at your current CDR. *If you suffer new impairments that began after the CPD date*, the medical consultant will not consider these in deciding if you have experienced *significant medical improvement*.

Because you may have new impairments that are not considered under the MIRS, a finding by the SSA that you have significant medical improvement does

not necessarily mean that your overall medical condition has significantly improved. The impact of new impairments on your ability to work is considered by the SSA only if you are found to have significant medical improvement in regard to impairments that were present at your CPD. (New impairments are further discussed in Subsection 2d.) Of course, if you do not have significant medical improvement in the impairments that got you disability, then your benefits will continue and there will no point in reviewing your new impairments.

Medical severity is determined by evaluating symptoms, signs and laboratory abnormalities.

- **Symptoms** are your own description of your physical or mental impairment. Common examples include “My back hurts,” “My abdomen hurts,” “I have chest pain,” “I’m cold,” “I’m tired,” “I’m dizzy,” “I’m short of breath,” “I’m scared” and “I feel worthless.” For children who cannot describe their symptoms, the SSA will accept the statements of parents or guardians who know the child best.
- **Signs** are physical or psychological abnormalities that can be observed apart from your statements (symptoms). A sign could be a missing limb, a skin rash, an abnormal reflex, a fast pulse, sweating, struggling to breathe, bleeding, a tremor, an epileptic seizure, decreased emotional expression, agitation, paranoid delusions or many other things.
- **Laboratory findings** are physical or psychological facts that can be shown by use of diagnostic techniques such as chemical tests, x-rays or other imaging studies, EKGs or psychological tests. Signs and laboratory findings must be evaluated by methods generally acceptable to the scientific medical community. For example, reports claiming to diagnose disease or severity of disease from examination of the colored part of the eye (iridology), or as a result of “therapeutic touch” would not be accepted by the SSA because they are not acceptable to the scientific medical community.

Disorders Showing Temporary Improvement

If the severity of your disorder fluctuates, the SSA is supposed to take this into consideration when considering medical improvement. For example, let's say your rheumatoid arthritis flares up every three or four months and then is better for several months. The severity of your impairment should be stable for six months to a year before the SSA decides you have improved enough to have your benefits terminated. Multiple sclerosis and systemic lupus erythematosus (SLE) are examples of other physical conditions that can act in this way and are frequently seen by the SSA.

Mental disorders can also show a lot of variation in severity—such as manic-depressive psychosis. The SSA is obligated to look at all of your medical history “longitudinally”—that is, to evaluate how your impairments affect you over a period of at least 12 months before a decision to stop your benefits.

How the MIRS is applied to physical disorders, mental disorders and a combination of the two can be found in the following examples:

Physical disorders. Chapters 7 and 8 explain the listing of impairments and residual functional capacity (RFC), and how they enter into the decision of whether or not you qualify for disability benefits. If you move up at least one exertional level of severity, such as from meeting or equaling a listing to an RFC rating for sedentary work capacity, or from sedentary work to light work, or from light work to medium work, or from medium work to heavy work, then you clearly have experienced a significant medical improvement.

EXAMPLE: Two years ago, after Kota's diseased heart valve resulted in heart failure, she was granted disability benefits. She was restricted to nothing more than sedentary work in her RFC rating. Subsequently, she had heart surgery with placement of a new valve. During the CDR, the DDS medical consultant found her capable of performing light work—and therefore found significant medical improvement.

Medical improvement that remains *within* a physical RFC exertional level may or may not be significant. In

the following example, improvement is significant even though the exertional level remains at light work.

EXAMPLE: At Rick's previous CDR, he was given an RFC for light work because of asthma and arthritis in his spine. Since then, Rick has had treatment for the asthma and breathes much better according to both his symptoms and objective pulmonary function tests. He's had significant medical improvement because of his improved breathing. His arthritis still restricts his lifting to light work, however.

Mental disorders. If you move up at least one mental skill level of severity, such as from meeting or equaling a listing level to a mental RFC rating compatible with unskilled work capacity, or from unskilled work to semiskilled work, or from semiskilled to skilled work, then you clearly have experienced a significant medical improvement.

EXAMPLE: Julie is a 35-year-old college-educated CPA with a ten-year history of successful skilled work, who suffered a major depression. She was initially granted benefits a year before the current CDR by meeting listing for major depression. That was her first episode of major depression and her prognosis was favorable. Julie has received ongoing treatment, and while she still has some signs of depression, she has significantly improved to the extent that she now has a mental RFC for unskilled work. Although Julie is not fully recovered from her depression, her ability to do unskilled work represents significant medical improvement.

Medical improvement that remains *within* a mental RFC skill level may or may not be significant. As discussed in Chapter 9, claimants with mental impairments alone who are restricted to semiskilled or skilled work are never granted benefits. Even those with the ability to do unskilled work are rarely granted benefits. In the rare instances in which they are, their age, education and work experience would probably result in a continuance of benefits on review.

Combined physical and mental disorders. Significant improvement in either a physical or mental impairment

alone can be sufficient to establish significant medical improvement.

EXAMPLE 1: Paul is a 34-year-old worker who fell off a roof and suffered a severe fracture of his spine. Even after maximum healing, he was capable of only sedentary work and no further improvement could be expected. His fifth grade education and work experience limit him to unskilled types of work. He also suffered significant anxiety that was worsened by his accident. Although neither his physical or mental impairment alone could satisfy the Listing of Impairments, he was awarded disability two years ago based on having multiple conditions equivalent in severity to the requirements of a combination of physical and mental disorder listings. Following treatment of his anxieties with psychotherapy and medication, his mental impairment has become not severe and he has experienced significant improvement in his mental condition.

EXAMPLE 2: Cindy is 50 years old with 25 years experience as a laundry worker. She has subaverage intelligence with an IQ of 68, which limits her to unskilled work. She is not mentally retarded. She has no other mental impairment. She has always been outgoing, friendly and capable of taking care of her own personal needs. Two years prior, she had suffered a fractured tibia that was somewhat slow in healing, and she was granted benefits based on her subaverage intellect and the fracture. Her fracture is now completely healed without any significant residual problem, and the SSA determines that there has been significant medical improvement.

Trivial impairments. If you experience great improvement in a trivial impairment, the DDS team should not find a significant medical improvement.

EXAMPLE: Maria was originally granted disability because of a heart disease; at the same time, she also had a minor case of athlete's foot. At her CDR, the MC determined that her athlete's foot was cured and her heart disease was the same. Maria has not had significant medical improvement. If

the heart disease had improved significantly, significant medical improvement would be obvious.

b. Your Ability to Work

If the MC finds that you have experienced significant medical improvement, your benefits will not be automatically terminated. A DDS examiner or vocational analyst must also show that you are capable of performing some work available in the national economy. The DDS examiner must take into account your original impairments and any new impairments you might have. (See Subsection C2d regarding new impairments.)

EXAMPLE: Max is 55 years old, has a third grade education and has always done heavy work. He was originally allowed benefits because of multiple unhealed fractures and arthritis in his spine. At the time of his CDR, his fractures have healed and the DDS finds significant medical improvement. But Max's spinal arthritis still restricts him to an RFC for light work. He will continue to receive benefits because the SSA will not be able to show any job that he can perform with his RFC, age, education and work experience.

Either a mental impairment or your vocational factors can influence the skill level of work that you can perform. When the SSA considers whether there are jobs you can perform, the SSA must use your lower skill level. In other words, you can be normal mentally but you are still not going to be able to work at levels of skill higher than those supported by your education and work experience. Similarly, you could have education or work experience that would support skilled work, yet be capable of only unskilled work due to a mental impairment.

c. Age and Time Receiving Disability

Age is usually not a factor to the SSA in deciding your physical capacity on an RFC. CDRs are an exception, however. The SSA knows that older recipients may be affected by aging and long periods of inactivity from not working. Aging and inactivity are often associated with decreased heart and lung function, weakening of muscles, degenerative joint changes and decreased

The Lesser the Disability, The Less Room There Is for Improvement

One of the amazing things about the MIRS is that if you were granted benefits in a situation in which you really weren't entitled, they can't be taken away except in limited situations. Through errors in judgment by someone working in the SSA, it is possible for people who actually have mild impairments to be initially allowed by being judged as much worse than they actually are. For example, you might have a mild or slight disability, rather than the severe one, but you were wrongly allowed under a rating for less than sedentary work. Because the law does not allow the judgment of past decision makers to be questioned, you can be in benefit status the rest of your life.

How can this happen? Once you get to the ALJ level of appeal, your claim in many instances will be treated with extreme leniency. For example, an ALJ might very well allow your claim after a DDS medical consultant gave you a higher RFC rating, or even after a DDS medical consultant rated your claim as not severe.

Now look at what happens when your claim later comes up for CDR evaluation. The ALJ has given you a rating for less than sedentary work, which would allow benefits for any claimant with any age, education or work experience (See Chapters 7 and 8 for more about RFCs). This less-than-sedentary RFC rating also evades the Listings, which have very specific requirements. The DDS MC who looks at your claim on CDR might think, "There's nothing really seriously wrong with this person medically." But remember, medical evidence between the CPD and current CDR must be

compared to determine if there is any medical improvement. If there's nothing much wrong with someone at the CPD and still nothing much wrong with them at their CDR, there is no room for significant medical improvement—there is no significant impairment present that can undergo improvement.

In such a situation, and there are many, the DDS MC cannot legally find that significant medical improvement took place and you will be entitled to benefits indefinitely, because no matter how many CDRs you have in the future, there will never be significant improvement, since you were not significantly disabled to begin with.

In reality—in contrast to Social Security regulations—there is no question that medical doctors know more about medicine than ALJs or other nondoctors deciding appeal cases. Knowing this to be true, a DDS MC might try to say there is medical improvement when there really is none. They may do this because they think it is wrong for a person they know is not disabled to stay on the disability rolls. However, it is not legal to ignore the medical improvement requirement in such instances. Of course, statements would be made in the file by the DDS MC that medical improvement had occurred when the doctor knew that it had not.

You've got to watch out for this kind of intentional ignoring of the MIRS, because you may feel you're disabled even though a doctor doesn't think there's much wrong with you. You still get the protection of the law, no matter who is right—if you get one of these less-than-sedentary RFCs from an ALJ, medical improvement can never be demonstrated.

general exercise capacity. How severe the changes are and when they appear, varies greatly among people.

The SSA considers age and inactivity if you are over age 50 and have been receiving disability benefits for at least seven years. These factors enter in when the DDS considers your current RFC rating and if you've had significant work-related medical improvement. Age and time on the disability rolls can result in continuation of benefits when the decision is a close one. The SSA may have you undergo tests if the available evidence does not indicate how much physical work you can do based on your age and time receiving disability benefits.

2. When the MIRS Doesn't Apply

Under certain conditions, the SSA doesn't have to apply the MIRS to your CDR evaluation. In these cases, you might be able to keep your benefits without the DDS doing a review for medical improvement. On the other hand, it is possible that without the protections of the MIRS you could lose your benefits.

a. Your Impairment Meets or Equals a Listing

If you are an adult and your impairment continues to meet or equal the same listing in the Listing of Impairments (see Chapter 7, Step 3), as it did at the time you obtained disability benefits or at your last CPD, then the SSA can simply continue your benefits without having to consider the MIRS. You will continue to receive your benefits even if the requirements of the listing have been changed and you do not meet these requirements of the new listing. This is extremely important to know; many disability recipients, especially those with heart or other cardiovascular disease, were granted benefits under lenient listings that are now out of date. An inexperienced or poorly trained DDS medical consultant might overlook this "grandfathering" clause and terminate your benefits.

Similarly, if you qualify as an adult under any newer listings in effect at the time of your CDR—even if you originally qualified under older, different listings—your benefits will continue without a medical improvement evaluation. Moreover, meeting or equaling the listings in effect at the time of the CDR can also

include any new impairments you have acquired since your CPD and also would not require a medical improvement evaluation.

In children, the rules are a little different in that qualification under a listing is decided only after a determination that there has been significant medical improvement. (See Section D.)

b. You Are No Longer Disabled or Never Were

If the DDS finds that you are no longer disabled or never were disabled, the SSA can terminate your benefits without applying the MIRS if you are performing substantial gainful activity (SGA) (see Chapter 1, Section B) or are capable of doing so. These are called Group I exceptions, and include the following: **You have undergone vocational therapy related to your ability to work.** This exception does not apply to SSI recipients eligible to receive special SSI cash benefits.

EXAMPLE 1: Tanya was found to be disabled when her impairment allowed her only to do work with a sedentary level of exertion. Her prior work experience was in work that required a medium level of exertion, and her age and education at the time she was awarded benefits would not have qualified her for work below the medium level. Since then, Tanya has completed a specialized training course that qualifies her for a job as a computer programmer. During her CDR, the DDS concluded that Tanya has had no medical improvement and can still do only sedentary work. Because the work of a computer programmer is sedentary in nature, however, Tanya is now able to engage in SGA and is no longer eligible for disability.

EXAMPLE 2: Jacques qualified for disability because the medical evidence and RFC showed he could do only light work. Jacques's prior work was heavy, and his age, education and prior work qualified him for work no less than medium in exertion. The current evidence and RFC show no medical improvement and that he can still do only light work. Since Jacques was originally awarded benefits, his vocational rehabilitation agency successfully

enrolled him in a trade school course and he can now do small appliance repair. This is considered light work. With these new skills, Jacque is now able to engage in SGA even though his RFC has not changed.

Based on new or improved diagnostic or evaluative techniques, your impairment is not considered to be as disabling as it was considered to be at the CPD. For this exception to apply, the new or improved techniques must have become generally available for medical use after the CPD.

EXAMPLE: Ginger has heart disease. At the time of her CPD, her heart function was measured with the Master's Two-Step Test. Since then, the EKG Exercise Test has replaced the Master's Two-Step Test as a measurement of heart function. Using the EKG Exercise Test, Ginger's condition is not considered as disabling as was previously thought. If Ginger is able to engage in SGA, she would no longer be considered disabled even though she's had no medical improvement.

A prior disability decision was erroneous. The DDS must find clear evidence that any prior decision granting you disability was in error. A difference in judgment between the past and current reviewers is not sufficient. The DDS can make this determination in one of three ways:

1. Clear evidence (not open to judgment) already documented in your file shows that the decision in question should not have been made.

EXAMPLE: Rory was granted benefits when the SSA determined that his epilepsy met Listing 11.02 in the Listing of Impairments. Listing 11.02 requires a finding of major motor seizures more frequently than once a month. On a review of Rory's original SSA file, the DDS team finds a history of seizure frequency once or twice a year. The prior decision was erroneous, and whether Rory now will be considered disabled will depend on whether he can engage in SGA.

2. At the time of the CPD, required material evidence of the severity of your impairment was

missing. That evidence is now available. Had it been present at the time of the CPD, you would not have been found disabled.

EXAMPLE: Lance was originally found disabled on the basis of chronic obstructive lung disease. The severity of his breathing impairment was documented primarily by a pulmonary function test. Spirometric tracings of this test, although required by SSA regulations, were not obtained at the time of the CPD. A review of the tracings later obtained during the CDR shows that the test was invalid. Lance's current pulmonary function test supported by spirometric tracings reveals that his impairment does not limit his ability to perform basic work activities in any way. Lance is no longer entitled to disability.

3. New evidence related to the prior determination of an allowance or continuation of benefits refutes the conclusions that were based on the prior evidence. Had the new evidence been present at the time of the CPD, you would not have been found disabled.

EXAMPLE: K'ia was originally allowed benefits because of a lung tumor thought to be cancer. Because she had other health problems at the time, the doctors did not do a biopsy of the tumor. After K'ia began receiving benefits, she had a biopsy and the tumor proved to be benign. K'ia is no longer entitled to disability.

Remember that difference in judgment between the past and current reviewers is not sufficient to find error, as illustrated by the following example.

EXAMPLE: Tim was previously granted disability benefits on the basis of diabetes mellitus, which the prior DDS MC believed was equivalent to the level of severity contemplated in the Listing of Impairments. At the time of the CPD, Tim had hard to control ("brittle") diabetes for which he was taking insulin. Tim was spilling extra sugar into his urine, and claimed occasional low blood sugar (hypoglycemic) attacks caused by exertion. During the CDR, the MC finds no change in Tim's

symptoms, signs and laboratory results. The current MC believes, however, that Tim's impairment does not equal the severity contemplated by the Listings. Nevertheless, Tim continues to receive disability, because one SSA decision maker cannot substitute his or her judgment for another.

You currently engage in SGA. This exception does not apply to SSI recipients. It also does not apply if you receive SSI or SSDI during a trial work period or reentitlement period. (See Chapter 13 for a discussion of these terms.)

You are the beneficiary of advances in medical or vocational therapy or technology related to your ability to work. Because such advances usually result in significant medical improvement, rarely would this exception have any practical application. This exception does not apply to SSI recipients eligible to receive special SSI cash benefits.

c. Something Other Than Disability Disqualifies You

In a few rare situations, you may automatically lose your entitlement to SSI or SSDI for reasons unrelated to your disability. These are called the Group II exceptions. The SSA can apply these exceptions without considering your medical improvement or ability to work. The Group II exceptions are as follows:

The SSA is unable to find you. If the SSA can't find you, the SSA will find that your disability has ended (see Chapter 11, Section C).

You do not cooperate with the SSA. If the SSA asks for medical evidence, for other evidence or for you to undergo an examination by a certain date and you refuse without good reason, the SSA will find that your disability has ended (see Chapter 11, Section D).

You fail to follow a prescribed treatment which is expected to restore your ability to engage in SGA. If you can't show a good reason for not following that treatment, the SSA will find that your disability has ended (see Chapter 11, Section E).

You committed fraud. Committing fraud means you gave the SSA false or misleading information during any prior decision about your benefits (see Chapter 11, Section H).

d. New Impairments

The SSA does not consider any new impairments you develop after the CPD date as part of the medical improvement decision. In adults, new impairments either meet or equal a listing or are evaluated after the issue of significant medical improvement is decided. In children new impairments are only evaluated after a determination of whether there is significant improvement (see Section D.) But what if you develop a significant new impairment during or near the time you are having your CDR? In this case, your medical condition could be unstable, making the disability determination more difficult. The following example illustrates the procedure that should be followed.

EXAMPLE: Paul was originally allowed disability for lung cancer. Three years ago he underwent successful surgery to remove a lung and there has been no sign of recurrence. Because of a history of cigarette smoking he has lung disease, so the severity of his breathing problem will need to be determined. The SSA sends him a notice that it intends to do a CDR on his claim. Two weeks after being notified of his CDR, Paul is hospitalized with a heart attack and may also require heart surgery within the next month. The DDS medical consultant can postpone or carry out the CDR. If the MC believes Paul's disability from his lung disease is enough to approve continuing his benefits, the CDR would be held. If it is unclear how Paul's recovery from his lung disease or heart attack will affect the ultimate outcome of his claim, the CDR should be postponed.

D. Children and CDRs



Children under age 18 who receive benefits as dependents of an SSDI recipient do not undergo continuing disability reviews, since these benefits do not depend on the health of the minor. This section only applies to CDR evaluations for SSI children.

SSI child CDR evaluations differ in some ways from the CDR evaluations of adult SSDI or SSI claims. First, the medical improvement determination in SSI children never involves changes in RFCs because children don't receive RFCs. Second, the order of CDR steps is a little different—the issue of medical improvement is considered before a decision is made whether the child meets or equals a listing. Third, the issue of “related to the ability to work” is not considered by the SSA. Still, the main question is whether the child has experienced significant improvement in his or her impairments. The analysis used by the SSA is as follows:

- Step 1. Has the child experienced significant medical improvement in the impairments present at the CPD? If “no” and none of the exceptions apply, benefits will continue. If “yes,” proceed to Step 2.
- Step 2. Do the impairments still meet or equal the severity of the listing that met or equaled at the time of CPD? If “yes” and none of the exceptions apply, as described in Sections C2b and c above, then benefits will continue. If “no,” proceed to Step 3.
- Step 3. Considering all of the child's current impairments—both those present at the CPD and new ones—do the impairments meet or equal a current listing? If “yes,” then benefits will continue. If “no,” benefits will end.

E. Appealing a CDR Decision

Once the SSA makes its CDR decision, you will receive a notice. If the SSA decides you are still disabled, your benefits will continue.

If the SSA determines that you are not still disabled, the SSA will send you a personalized explanation explaining how it reached its determination. If you don't appeal, your benefits will stop three months after the SSA said your disability ended, with the further condition that your benefits cannot be stopped earlier than the date of your cessation decision.

This prevents the SSA from demanding back benefit repayment from you by saying that your disability ended before they even conducted your CDR. For example, suppose you were significantly improved and able to work a year before the SSA did a CDR evaluation of your claim. That is the SSA's fault, not yours, and you won't have to repay that money.

The only exception would be if you had committed fraud to obtain benefits; in that case the SSA could demand repayment of all paid benefits. What if the SSA decided that your disability ended on the date the SSA says your benefits are ceased? In that case, your benefits would continue for three more months and then be stopped. (See Chapter 12 for information on appealing denied claims.) ■

Chapter 15

Your Right to Representation

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You do not need to represent yourself in a disability claim. You can appoint someone in writing to be your *authorized representative* to deal with the SSA on your behalf. (42 U.S.C. § 406; 20 CFR §§ 404.1700, 416.1500.) SSA personnel will work with your representative, just as they would work with you. The primary role of the authorized representative is to pursue your claim for benefits under SSDI or SSI.



An *authorized representative* is different from a *designated representative*—a person you can appoint to look at your medical records, and is different from a *representative payee*—a person you can appoint to handle your benefit checks. Of course, you could name the same person to be your authorized representative, designated representative and representative payee. (Designated representatives are discussed in Chapter 2 and representative payees are discussed in Chapter 13.)

A. When Do You Need an Authorized Representative?

Many people are perfectly capable of applying for disability benefits themselves and most claimants do just that. They have the time and ability to complete the paperwork, meet with the claims examiner, contact their treating doctors and hospitals for their medical records and follow up on any requests from the claims examiner, medical examiner or medical consultant.

Other people appoint authorized representatives to handle their application for benefits. Typical reasons for appointing such a person include the following:

- You just don't want to handle your own claim.
- Your medical condition prevents you from effectively representing yourself.
- You don't have the time to represent yourself.
- You have limited education or English skills and want someone to help with the paperwork.

Many people decide to appoint an authorized representative only if their initial claim for benefits (and perhaps a reconsideration) has been denied and they want to appeal. Mind you, not everyone has an authorized representative for an appeal—many claim-

ants handle their appeals on their own, particularly at the administrative level. (Chapter 12 has complete information on appealing.)

On the other hand, a formal appeal means arguing your case before an administrative law judge (ALJ), an attorney who works for the SSA and reviews the decisions of the Disability Determination Service. You also may not feel you have the skill to represent yourself. And if you lose your case before the ALJ, you can appeal to a federal district court. At that point, it would be in your best interest to hire an attorney as your authorized representative. (See Section D, below.)

Ultimately, the decision of whether or not to hire a representative requires judgment on your part—a judgment that often relates to money. If, after reading this book, you conclude that there is a really good chance you will be granted benefits, then there is little reason to spend money on hiring someone—usually a lawyer—to submit your application and let the SSA make its decision. But if you are uncertain, or you've been denied benefits and want to appeal, then hiring an authorized representative may make sense. You need to balance the fee you'll have to pay the representative against the amount of money you potentially could recover if you are awarded benefits. (Fees are discussed in Section E, below.)

B. What Can an Authorized Representative Do?

An authorized representative can act for you in most Social Security matters, including the following:

- accompanying you or attending on your behalf any interview, conference or hearing with the SSA or DDS
- helping get medical records or information from your treating sources to support your claim
- obtaining information from your Social Security file
- requesting reconsideration of your claim, a hearing or an Appeals Council review
- helping you and your witnesses prepare for a hearing
- presenting your case at a hearing and questioning any witnesses, or

- filing an appeal beyond the Appeals Council—that is, in court—if the representative is an attorney.

All correspondence will be sent to you and your representative. However, it is a good idea for you to inform your representative of any communications from the SSA in case by some error the representative doesn't get a copy. Even though you have appointed a representative, you (through your representative) remain legally obligated to provide Social Security with accurate information.

A representative usually may not sign an application for disability benefits on behalf of a claimant, but there is nothing to prevent a representative from helping the claimant fill out the forms. If there is a good reason why the claimant cannot sign the application, however, the SSA may accept an application signed by someone other than the claimant—such as a representative.

EXAMPLE: Joe is a 55-year-old widower who had a heart attack a few days before the end of the month, and was unable to file an application for SSI disability benefits. However, he hired authorized representative Sinclair to help him with his claim. The Social Security office accepted an application for Joe signed by Sinclair, because it would not be possible to have Joe sign and file the application until the next calendar month—which would mean that Joe would lose one month's benefits.

C. Who Can Be an Authorized Representative?

Authorized representatives generally fall into two categories—attorneys and nonattorneys. Your Social Security office has a list of organizations that can help you find an authorized representative.

1. Attorney Representatives

Any attorney in good standing, licensed to practice in the United States, can serve as your representative in

dealing with the SSA. The only exceptions are if the attorney has been disqualified or suspended from acting as a representative in dealing with the SSA (see Section 3, below) or is otherwise prohibited by law from acting as a representative.

If the attorney you hire is a member of a law firm or organization, you can appoint a second or third person within the firm (corporation, LLC or partnership) or organization as additional representatives to handle your case if your first representative is unavailable. Note that Social Security rules bar you from appointing a firm, corporation, LLC, partnership or organization itself. You must name a specific person to be your authorized representative.

2. Nonattorney Representatives

You can appoint anyone you want to be your representative in dealing with the SSA as long as that person has a good character and reputation, can give you valuable help with your claim, has not been disqualified or suspended from acting as a representative in dealing with the SSA (see Section 3, below) and is not otherwise prohibited by law from acting as a representative. The law does not define what good character is, but it most likely means they have not been convicted of any serious crimes.

3. Suspended or Disqualified Representatives

On occasion, the SSA suspends or disqualifies people from serving as authorized representatives. The reasons for doing so include such activities as knowingly and willingly providing false information to the SSA or charging an unauthorized fee for services. If you attempt to name someone as your authorized representative who has been suspended or disqualified, the person's name would pop up in the SSA's computers as suspended or disqualified. If you want to check beforehand, call the SSA Hotline (800-772-1213). Tell the person who answers that you want to find out if the person you are considering appointing to be your authorized representative has been suspended or disqualified by the SSA.

D. Should Your Authorized Representative Be an Attorney?

If you want to appoint an authorized representative, you must decide between an attorney and a non-attorney. The same general analysis suggested at the end of Section A, above, applies here: If you are at the application stage and don't foresee too many problems, then a nonlawyer representative might serve you just fine. The same is true even at the administrative appeal level. There are undoubtedly very capable and highly experienced nonattorney representatives who can represent your claim before an administrative law judge.

If your case is questionable from the outset or you've been denied benefits and are filing a reconsideration claim or an administrative appeal, then it will probably be to your advantage to have your representative be an attorney knowledgeable in disability rights. An attorney with extensive disability rights experience should be well equipped to handle the legal issues that arise in your claim. They know a lot about the SSA and its regulations. They can make sure that you do not miss deadlines, can help you obtain medical records that hospitals or treating doctors won't give the SSA and can call the examiner handling your file and ask questions on your behalf. Of course, if you know of a capable nonattorney who you trust and want to represent you, then by all means use that person. You could always change to an attorney later, if necessary. (Using an attorney as your representative is necessary if you appeal your claim to a federal court. No one else can serve as your representative there.)

Finding an attorney who handles disability claims isn't difficult. They advertise in the classified ad section of newspapers and in the telephone book. Of course, attorneys vary in their competence, skill and experience. Some attorneys are new to the field of Social Security disability representation of claimants. Disability law is an extremely specialized area. Attorneys cannot quickly review a few law books and capably represent your claim.

You should be cautious in retaining attorneys who only take occasional disability cases, while most of their time is spent in another kind of law practice. Some attorneys not only have extensive disability case experience representing claimants, but a history of

working in some other capacity that gives them additional valuable insights—former jobs such as being an SSA attorney, a former administrative law judge or a former DDS supervisor or examiner. You can call an attorney's office and find out the answers to these questions before making an appointment.

When considering whether to hire an attorney, you should ask yourself whether the attorney:

- is easy to relate to
- listens to what you have to say
- seems genuinely concerned with your disability problem
- is friendly—or aloof, and
- is willing to answer your questions in a way you can understand.

Many attorneys use paralegal assistants to help them with disability claims. This should be acceptable to you only as long as the attorney adequately supervises the paralegal, keeps up with what is happening in your claim and personally handles any significant legal events such as hearings. After all, you're supposed to be paying for attorney representation.

It is also important to find out what the attorney thinks about working with the DDS. If they bad-mouth the DDS medical consultants and examiners, it is not likely they have a good working relationship with the DDS staff. For example, some attorneys proudly proclaim how they have no interest in the opinions of DDS medical consultants or DDS job specialists (vocational analysts). This arrogant attitude cannot work to your advantage, since the SSA uses the opinions of such personnel to make disability determinations.

If the attorney says that the DDS denies everyone and that your only chance is at the administrative law judge appeal level above the DDS, watch out! This statement is not true. DDSs allow more claims than any other level of the SSA disability system. Appeals above the DDS can require one or more years. If your case drags on and you are eventually allowed benefits, you will get more past-due benefits (and the lawyer's share will also be higher), but can you withstand the hardship of being without your benefits that long?

Attorneys do not accept every case that comes to them. And because they usually insist on payment only if you win benefits (see Section E below), they spend considerable time judging whether or not you have a reasonable chance of being awarded benefits.

For example, if you're 25 years old and in good health, except for an artificial leg on which you walk well, an attorney is not likely to take your case because anyone experienced in the Social Security system knows that your chance for benefits is small. On the other hand, if your case is fairly complex and you're over age 55, the whole picture changes. In that instance, if an attorney says you don't have a chance, visit another attorney for a second opinion.

E. When and How Your Representative Is Paid

In both SSDI and SSI claims, attorneys and nonattorneys who represent disability applicants know that their clients don't have a lot of money to spend, and will usually work for payment subtracted from your past-due benefits if your claim is allowed. This means that, in most instances, if you lose your claim, you don't have to pay your authorized representative. To avoid any misunderstanding, be clear on the nature of the fee arrangement the representative offers before you hire him. However, you should understand that, win or lose, your representative may expect you to pay his out-of-pocket office costs associated with handling your claim. These might include long distance telephone calls, copying birth and death certificates, travel expenses or postage.

1. SSA Approval of Fee Agreements

The SSA must approve in writing all fee agreements between claimants and their authorized representatives. Your representative can accept money from you to be placed in an escrow account. The basic reason a representative would want to do this is to assure that you pay. For example, in SSI claims—unlike SSDI claims—the SSA does not withhold some of a claimant's approved disability benefits to pay the representatives. Therefore, the representative has to collect it from the claimant himself should the SSA or a federal court grant the claimant disability. To assure payment, the representative might ask the claimant to bring in a portion of their SSI benefit check to be placed in escrow pending a final determination by the SSA of how much money the representative is entitled to receive.

To request approval of a fee agreement from the SSA, your authorized representative must file a copy of the agreement with your Social Security Field Office *before* a decision has been reached on your claim. If the representative forgets to do this, they must use the fee petition process (see Section 2). Most representatives prefer fee agreements. Your representative must provide you with a copy of the fee agreement they send to the SSA. The SSA will consider the fee agreement and let you and your representative know of its decision. The SSA usually approves a fee agreement as long as:

- you and your representative both signed the agreement
- the fee you agreed to pay your representative is no more than 25% of your past-due benefits or \$5,300, whichever is less. Past-due benefits are those that you have yet to receive, dating back to the date the SSA determines you were eligible for benefits.

EXAMPLE: If it took a year from your onset date to get your claim approved, the SSA would owe you a year's worth of benefits. If that amount was more than \$16,000, your representative could only get \$5,300. Fee agreements can be used by both attorney and nonattorney representatives, and for both SSDI and SSI claims. However, the actual way the representative gets her money depends on several factors discussed below (see Section 3). Also, remember that you can be charged additional amounts for representation by a lawyer before a federal court (see Section 4), as well as a representative's out-of-pocket expenses.

- your claim is approved and you were awarded past-due benefits.

If the SSA does not approve the fee agreement, it will notify you and your representative that your representative must file a fee petition. (See Section 2.)



For the SSA's suggestion to attorneys regarding how to word their written fee agreement with you in a way that explains this approval system, see www.ssa.gov/representation/model_fee_agreement_language2.htm.

2. SSA Approval of Fee Petitions

Your authorized representative might not want to make a fee agreement with you, preferring the fee petition process as a means of collecting her money. Also, if the representative forgets to do a fee agreement or the SSA fails to approve the fee agreement, she must file a fee petition. The SSA will not accept fee petitions until a final decision has been made on your claim.

In the petition, your representative must state in detail the amount of time spent on each service provided to you. The representative must give you a copy of the fee petition. If you disagree with the information shown, you must contact the SSA within 20 days. You should contact your SSA Field Office in writing, and follow up with a telephone call a few days later to make sure they have your letter.

In evaluating a fee petition, the SSA looks to the reasonable value of the services provided. The SSA may approve your representative's request to charge you, but not the amount in the petition. In that case, the SSA will tell you and your representative the approved amount. Your representative cannot charge you more than the approved amount, except for out-of-pocket expenses—such as the cost of getting your doctor's or hospital records. If you or your representative disagree with the approved amount, the person who objects can ask the SSA to look at the petition again.

A representative who charges or collects a fee without the SSA's approval, or who charges or collects more than the approved amount, may be suspended or disqualified from representing anyone before the SSA, and may face criminal prosecution.

The SSA fee agreement and fee petition process do not to apply to claims that are appealed to federal court. (See Section 4, below.)

3. How Your Representative Is Paid

If your representative is an attorney, the SSA usually withholds 25% of your past-due SSDI benefits to put toward your attorney's fee and sends you anything left over after the lawyer is paid. If the SSA fails to withhold the attorney's fee, you must pay the attorney

out of your benefit amount. If you do not pay, the SSA can withhold the amount you owe your attorney from future benefits.

You must pay the representative directly if:

- Your representative is not an attorney.
- You were awarded SSI. (The SSA doesn't withhold 25% of the benefits in SSI cases.)
- Your attorney did not request fee approval or did not request it on time.
- The fee is for more than the amount withheld by the SSA, in which case you must pay the balance.

4. Attorney Representation in Federal Court

It is possible to appeal your case to federal court if the SSA denies your claim and any administrative appeals. A federal court can order the SSA to allow or deny your claim, or it can instruct the SSA to obtain more information. To get your claim into federal court, you must file a formal appeal using an attorney.



Fee agreements and fee petitions refer to formal payment arrangements that must be approved by the SSA. We use the term "payment arrangements" to refer to other aspects of the financial arrangement between attorneys and claimants.

If you appeal to federal court, the court can allow a reasonable fee for your attorney for the part of your representation that involves the court proceedings. This fee is *in addition* to any fee agreement you and your attorney may have with the SSA. Remember that the courts and the SSA are two different organizations; when you enter the federal court system, you have left the SSA behind. Whether or not you have to pay your attorney for representing your claim in federal court depends on the type of payment arrangement you have with your attorney. The SSA has no authority to approve or disapprove attorney charges for court representation.

It costs money to go to court, and claimants frequently don't have the means to pay for such representation. Therefore, an attorney will not take your case to federal court unless he thinks there is a reasonable chance of winning, since, if you lose, he

will have to pay court costs in addition to not getting paid for representing you.

On the other hand, if the payment arrangement you have with your attorney says you will have to pay for court representation, then the cost could be your burden—the arrangement might be that you only pay if you win, or you might have to pay whether you win or lose.

If you lose your case in federal court, you will not be considered disabled and you will receive no future or past-due benefits. Assuming your claim is approved, the court will order the SSA to consider you disabled and start paying you benefits. Based on when the federal judge decides the onset date of your disability, you will also be entitled to some past-due benefits from the SSA. If you have an SSDI claim, your past-due benefits could extend back to a time before you even applied for disability; if you have an SSI claim, the earliest onset would be the month after you apply for benefits (see Chapter 10). If you have both SSDI and SSI claims (concurrent claims), you can receive past-due benefits for both. Note that, if your attorney charges you for court representation in an SSDI claim, the judge can order the SSA to also take that amount out of your past-due benefits provided there is enough money there. Otherwise, you and your attorney will have to work something out regarding payment for court representation.

If you are granted disability benefits by the court, the method by which your attorney will be paid is not the same in SSDI cases and SSI cases. The differences are discussed separately in Sections a and b below. It is also important to understand that your fee agreement when you have both types of claims applies to the *total* SSDI and SSI benefits considered together *for that part of your fee that is for representation before the SSA*. In other words, under your fee agreement for the SSA representation, your attorney can only collect a total maximum payment of \$5,300 from your past-due benefits—not a \$5,300 maximum for your SSDI claim and another \$5,300 maximum from your SSI past-due benefits. This applies to claims approved at the federal court level and those approved before ever reaching a federal court.

Remember that when a claim is approved by a federal court, there are two payment issues that come up at the same time: the fee for your attorney for

previously representing you before the SSA, and the fee your attorney will charge you for federal court representation. It is not likely that an attorney is going to represent you in court unless you have enough past-due benefits to make it worth their while, or make other arrangements for payment. It is also important for you to understand that attorney payment issues can be extremely complex and, in some instances, controversial or without precedent. The comments in this section are meant to guide you in the most important general principles. They are not a substitute for expert legal advice. You should discuss payment issues in detail with your attorney, until you feel comfortable with what to expect to pay.

a. Attorney Payment for SSDI Claims Allowed or Denied in Federal Court

i. Payment for SSA Representation

To get paid by the SSA from your past-due benefits in an SSDI claim, your attorney must file a request for approval of his fees and submit this request to a Social Security office within 60 days of when you are notified of being granted benefits. Remember, this is SSA approval only for the SSA part of your representation. If your attorney does not meet the 60-day deadline, the SSA will send you and your attorney written notice that the SSA will send you all past-due benefits unless the lawyer asks for his fee within another 20 days. If your attorney still does not file the request on time, the SSA will send you all of your past-due benefits. As previously discussed, the lawyer's fee cannot exceed \$5,300 for your representation before the SSA. If you lose your SSDI claim in federal court, the fee agreement used by the SSA does not make you liable for any attorney payment, since the SSA has no authority over what your attorney charges for federal court representation.

ii. Payment for Federal Court Representation

What about the amount of federal court fees you might owe your attorney if you win? As a requirement of federal law 42 U.S.C.A § 406(b), the court part of your charges cannot exceed 25% of your total past-due SSDI benefits. Payment for federal court representation differs from payment for representing you solely within the SSA. Within the SSA, your represen-

tative is generally limited to \$5,300. At the federal court level, however, if 25% of your past-due benefits exceeds \$5,300, your attorney can charge you the difference, provided you previously agreed to that arrangement. In such an event, the lawyer requests the \$5,300 from the SSA directly and files a motion in the federal court for the difference. The SSA payment center will hold the excess until the federal court decides whether the attorney can have the extra money.

EXAMPLE: Your payment arrangement with your attorney stated that if 25% of your past-due benefits amounted to more than \$5,300, you would pay the attorney the difference. Your payment arrangement also stated that this extra amount would not exceed \$1,000. Your claim is allowed by the court and your past-due benefits are \$25,000. Twenty-five percent is \$6,250. Your attorney requests \$5,300 from the SSA and submits a request to the court to authorize the SSA to pay him another \$1,000. The total attorney fee would be \$6,300.

As discussed above, if you lose your case in federal court, the SSA will not pay your attorney out of your past-due benefits, because you won't have any money coming. Instead, you would have to pay your attorney yourself and the attorney would not have to get SSA or court approval.

b. Attorney Payment for SSI Claims Allowed or Denied in Federal Court

i. Payment for SSA Representation

If you win SSI benefits in federal court, the SSA must approve the fee agreement concerning that part of your representation before the SSA. The rules are the same as for SSDI claims—you are liable for a maximum of \$4,000. Just as in SSI cases that are allowed prior to the federal court level, the SSA will not withhold past-due benefits for your attorney. Instead, your benefits will be paid to you and you must pay your attorney. As previously discussed in Section E1, your attorney may ask that you turn over part of your past-due benefits to him so he can place it in an escrow account pending SSA approval of the amount for him

to be paid under the fee agreement. This happens because it is likely you will get your past-due benefits soon after you win in federal court, while the attorney might have to wait for months before final SSA approval of the amount of his payment. In the meantime you may have spent all the money, if your attorney doesn't require you give some to him to hold in escrow for his share. When the SSA approves a dollar amount of the fee agreement payment, the attorney can then take the escrow money for himself. As mentioned previously, the SSA has no authority over attorney fees for court representation, so if you lose your SSI claim in federal court, the fee agreement used by the SSA does not make you liable for any attorney payment.

ii Payment for Federal Court Representation

What about the amount of federal court fees you might owe your attorney if you win? Unlike SSDI claims, there is no federal law requiring your attorney to get the approval of a federal court or the SSA before charging you a fee for representing your SSI claim in court, whether you win or lose. Depending on your payment agreement with your attorney, you might well have to pay for your representation in court.

5. If Someone Else Pays Your Fee

If someone will pay your attorney's fee for you—for example, a long-term disability insurance company—the SSA still must approve the fee unless:

- the fee will be paid by a nonprofit organization or government agency, or
- your representative provides the SSA with a written statement that you will not have to pay any fee or expenses.

F. Notifying the SSA of Your Choice for Representative

Once you choose a representative, you must tell the SSA in writing by completing Form SSA-1696, Appointment of Representative.



You must use forms provided by the SSA. You can obtain them at your local SSA Field Office or by calling the SSA hotline at 800-772-1213, Monday through Friday (except holidays), from 7 a.m. to 7 p.m. If you are deaf or hard of hearing, TTY service representatives are available at the same times at 800-325-0778. You can also download many necessary forms from the Social Security Administration website at www.ssa.gov.

The location of your claim determines where you should send the form. If it is at a DDS office, send the form to a Social Security Field Office. If you have filed an administrative appeal of your claim, file the form with the SSA administrative office. If you are appealing an administrative law judge's decision to the Appeals Council, send the form to the Appeals Council. An attorney or other professional representative chosen as the representative should take care of these details for you.

On the form, you give the name and address of the person who is your representative. If your representative is not an attorney, she must give her name, state

that she accepts the appointment and sign the form. You also must sign the form and give your address, Social Security number and telephone number. If the claimant is not the same person as the wage earner (for SSDI claims), such as a parent signing for a child, the Social Security numbers of both are needed.



More information. If you have any questions about your right to representation, call the SSA at 800-772-1213.

G. Keeping Up on the Law Yourself

With or without a lawyer, you should realize that the material in this book can change between printings. The U.S. Congress and the Social Security Administration are constantly updating and revising the rules that affect you. To assist you, Nolo prints updates to all of its books on its website at www.nolo.com. Go to the Free Information and Tools portion of the homepage and click on "Legal Updates," then on the title of this book. ■

Chapter 16

Musculoskeletal Disorders and Growth Impairments

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Abduction. Movement of a limb away from the body in a right or left direction.

Adduction. Movement of a limb toward the body from a right or left position.

AK amputation (AKA). Above the knee amputation.

Ankylosing spondylitis. Inflammatory disease of the spine and its supporting ligaments, as well as of the sacroiliac joints and sometimes other parts of the body.

Ankylosis. When a joint or spine is fixed so that it can't move. Ankylosis may be caused by arthritis that fuses joint bones together. For example, an arthritic bone spur may grow across the space of the knee joint so that the joint cannot move. Ankylosis can also be caused by soft tissue damage around a joint, such as scarring of skin and inflamed, fibrosis of ligaments and tendons.

Anterior and lateral ligaments. Ligaments that run up and down the outside of the spine, helping hold the vertebrae in place.

Antibodies. See *immunoglobulins*.

Antinuclear antibodies (ANA). Abnormal antibodies are found in bodily fluids of many patients with autoimmune diseases, such as systemic lupus. They form in an area of cells called the nuclei, which contain genetic material controlling cell metabolism. ANA is reported by laboratories as degrees of abnormality called titers. The higher the titer, the more times a sample of serum can be diluted and still have abnormal levels of antibodies. A higher titer reading suggests a more severe disease. For example, an ANA titer of 1:150 means abnormal levels of the antibody are still measured when the bodily fluid has been diluted 150 times; a titer of 1:500 means an abnormal level exists after the fluid is diluted 500 times. Although it is possible for positive ANA results to occur in normal people, they would be in the low titer ranges of 1:20 to 1:40, which are generally interpreted as negative results.

Apophyseal articulations. Parts of the upper and lower surfaces of vertebrae that attach to the intervertebral discs and anterior and lateral ligaments, and run up and down the outside of the spine.

Arachnoiditis. Inflammation of all three membranes covering the spinal cord, and also involving nerve roots.

Arthralgia. Joint pain. Not the same as arthritis, which is disease affecting a joint. Arthralgia usually accompanies arthritis.

Arthrodesis. Surgical fixation of a joint by means of bone grafts taken from elsewhere in the body, such as a "triple arthrodesis" used to stabilize the ankle. Arthrodesis is also known as surgical fusion.

Atherosclerosis. Degenerative disease of the arteries, causing blockage of blood flow by fatty deposits.

Atrophy. To get smaller.

Biopsy. The process of taking a sample of tissue for detailed analyses of various kinds. Biopsy specimens are observed grossly with the eyes, microscopically with a variety of possible tissue stains, and in some cases may involve specific chemical and DNA analysis.

BK amputation (BKA). Below the knee amputation.

Bones. The skeleton of the body that provides support for softer tissues. The outer parts of bones are hard and stiff because they contain chemical compounds derived from calcium. Bones constantly dissolve and rebuild. Certain bones have a hollow interior containing marrow that is the manufacturing site for most blood cells.

Cauda equina. The nerves that hang down below the lowest end of the spinal cord, so named because of their resemblance to a horse's tail.

Cervical spine. Spine in the neck.

Chronic. Constantly present and incurable.

Computerized axial tomography (CAT or CT) scan.

X-rays taken under computer guidance that can show much greater detail than regular x-rays.

Congenital. Dating from birth.

Contracture. When a limb strongly resists movement from a fixed abnormal position as a result of fibrosis or scarring of ligaments, tendons, muscles or other soft tissues around joints. Contractures of limbs in a bent position are the most common and known as "flexion contractures."

Deep tendon reflexes (DTRs). Brief involuntary muscle contractions caused by stimulation of nerve endings in muscle tendons. For example, tapping on the patella (the tendon below the kneecap) normally causes contraction of the quadriceps (upper thigh muscle) so that the leg extends in a brief kicking motion. This is called a knee jerk (KJ). Biceps jerks (BJ) and ankle jerks (AJ) are other commonly tested deep tendon reflexes.

Degenerative. Characterized by the progressive breakdown of tissues to a less functional state.

Degenerative arthritis. See *osteoarthritis*.

Degenerative disc disease (DDD). Drying and thinning of the intervertebral discs, identified by the abnormal narrowing of the spaces between vertebrae. DDD is most commonly seen with aging.

Discectomy. Removal of part of an intervertebral disc, often done with a laminectomy. Sometimes, a micro-discectomy is possible by making a small surgical incision in the back without performing a laminectomy.

Dorsolumbar spine. Spine area in the lower part of the chest and upper part of the lower back.

Effusion (of joint). Abnormal collection of fluid in a joint space.

Epiphyses. The special areas of bone from which new bone is formed in growing children.

Erosion of bone. Areas of bone loss due to a disease process.

Definitions (continued)

Erythrocyte sedimentation rate (ESR). Test that measures how quickly red blood cells settle; the faster the settling, the more abnormal the result. An elevated ESR indicates some type of inflammation, not one particular disease. But it almost always increases greatly with severe joint inflammation, such as with active rheumatoid arthritis. While an elevated ESR by itself does not imply arthritis or joint inflammation, a normal ESR strongly argues against joint inflammation at the time the test is performed. A normal ESR is about ten mm/hr or less in men and 20 mm/hr or less in women, depending on the method used by the reporting laboratory.

Facet joints. Small joints between vertebrae.

Femur. Large bone in the thigh. The upper end of the femur forms the lower part the hip joint. The lower end of the femur forms the upper part of the knee joint.

Fibrosis. Degenerative process involving the replacement of normal tissue with fiber-like tissue. Fibrosis is always abnormal, while the word “fibrous” may refer to either normal or abnormal fiber-like tissues.

Fine movements. Coordinated manipulation with the fingers, such as picking up coins, buttoning a shirt, typing, playing the piano, or handling anything with the fingertips.

Forced vital capacity (FVC). Maximum volume of air that can be expired through the mouth with maximum effort, after taking as deep a breath as possible.

Fusion of spine (surgical). Placing living bone strips between adjacent vertebrae. The bone strips become incorporated with the vertebrae, fusing them together. The bone strips are taken from the top part of the pelvic bone.

Gross movements. Grasping and holding onto fairly large objects with the entire hand, for example turning a doorknob, lifting a pan or handling a wrench.

Hemipelvectomy. Removal of the right or left pelvic bones.

Herniated nucleus pulposus (HNP). Protrusion of the cartilage-like central part of an intervertebral disc through its fibrous covering. Herniated nucleus pulposus is a frequent cause of radiculitis (inflammation of a spinal nerve root) and back pain and is commonly called a herniated disc.

Hip disarticulation. Amputation of an entire lower extremity through the hip joint.

Humerus. Arm bone, connecting the shoulder and elbow.

Hypertrophic arthritis. See *osteoarthritis*.

Immunoglobulins (Ig). Chemicals produced by plasma cells that are part of the body's immune response to antigens. Immunoglobulins perform many specialized functions. The various types of immunoglobulins are G, M, A, D and E. These are abbreviated as IgG, IgM, IgA, IgD and IgE. Also known as *antibodies*.

Inflammation of joints or other tissues. Redness, swelling, pain, warmth and tenderness. Because skin tones vary, a lack of redness doesn't rule out inflammation if the other findings are present.

Instability. When bones in a joint slip out of alignment under normal amounts of stress. For example, an unstable knee joint

is liable to give way when weight is placed on it. Instability may be caused by arthritic deformity, destruction of a joint or weakness of ligaments around a joint that normally stabilize it. Ligaments may be damaged by inflammation associated with some types of arthritis.

Intervertebral discs. Discs that separate and cushion the vertebrae.

Iridocyclitis. Inflammation of the eye's iris and ciliary body.

Joints. Spaces between bones. The ends of bones that form joints are often covered with cartilage. Joints are moistened with a substance called synovial fluid, which permits smooth motion with a minimum of friction. Synovial membranes surround joints and produce synovial fluid.

Kyphosis. Curvature of the spine normally present to a mild degree in the thoracic spine. The spine looks as if a flexible straight rod was pulled backward from behind while the bottom remained in place. The lay term is hunchback.

Laminectomy. Surgery to remove of a part of a vertebra known as its lamina. Laminectomies are done to relieve pressure on spinal nerve roots that often result in a herniated nucleus pulposus or arthritic spurs.

Ligaments. Flat, flexible, tough connective tissue that extends between bones and across joints to hold bones in position.

Limp. Avoidance of weight-bearing on one leg.

Lordosis. Curvature of the spine normally present to a moderate degree in the lumbar spine and to a mild degree in the cervical spine. The spine looks as if a flexible straight rod was pushed forward from behind while the bottom remained in place. The lay term is swayback.

Loss of motion (LOM). See *range of motion*.

Lumbar spine. Spine area in the lower back.

Magnetic resonance imaging (MRI). Method of producing pictures of internal body structures using magnetic fields and radiofrequency fields. MRIs do not utilize x-rays or other radiation.

Muscles. Relatively soft structures that consist of complex proteins with the ability to shorten and lengthen. Skeletal muscles move bones by contracting across joints.

Muscle spasm. Involuntary contraction of a muscle that cannot be relaxed by an act of will.

Myelography. X-ray technique for seeing pressure put on the spinal cord or nerve roots by herniated discs, arthritis or tumors.

Nerve root. The first part of a nerve as it is formed from the spinal cord.

Nonradicular pain. Pain that does not follow the distribution of any specific nerve root.

Nonunion. Failure of a bone fracture to heal.

Orthosis. An artificial device that corrects or supports the function of some body part. For example, many people use an ankle-foot orthosis (AFO), a below-the-knee appliance that supports the ankle and foot.

Definitions (continued)

Osteoarthritis (OA). Most common type of arthritis, especially associated with aging; it is characterized by bony outgrowths, such as the narrowing of joints, and spurs around joints or in the spine. Also known as *hypertrophic arthritis* or *degenerative arthritis*.

Osteomyelitis. Infection of bone.

Osteoporosis. Loss of bone mass—that is, a thinning of bone substance.

Pelvic bones (pelvis). Ilium, ischium and pubis.

Percentile. Method of comparing something, like height or weight, to normal expected values, in order to decide the probability that it is normal or abnormal. For example, a person with a weight in the 60th percentile is heavier than 60% of other people and lighter than 40% of other people.

Pericarditis. Inflammation of the membrane surrounding the heart; a possible complication of rheumatoid arthritis.

Peripheral vascular disease. Any of several disorders affecting the arteries supplying the arms or legs with blood, the most common of which is caused by atherosclerosis, the buildup of fatty deposits.

Prosthesis. A cosmetic or functional artificial device that replaces a body part. Examples include prosthetic legs, arms, eyes and joints.

Pseudoclaudication. Pain, usually of dull and aching quality in the lower back and thighs, accompanied by weakness in the lower extremities and caused by lumbar stenosis putting pressure on the spinal cord. Pseudoclaudication can be precipitated by standing, walking or bending backward. It may be lessened by leaning forward. The pain is nonradicular.

Radicular distribution. The specific body area served by a particular nerve root from the spinal cord.

Radicular signs. Neurological signs in a limb indicating an irritation of the spinal nerve root of a particular limb. Radicular signs are decreased deep tendon reflexes, muscle weakness, pain and decreased sensation.

Radius. Large bone in the forearm between the elbow and wrist, on the same side of the forearm as the thumb.

Range of motion (ROM). How well a joint moves. ROM is extremely important in determining how limiting arthritis is likely to be. For example, a knee joint that has only a small degree of motion will limit the ability to walk and otherwise use the legs much more than a knee with a normal or mildly restricted range of motion. ROM may be limited not only by arthritis, but also by loss of flexibility in soft tissues around joints. ROM is usually reported in degrees of flexion (bending of a limb or the spine) and extension (straightening a limb), abduction (movement of a limb away from the body in a right or left direction), adduction (movement of a limb toward the body from a right or left position), rotation, etc., depending on the joint involved.

For Social Security disability purposes, all musculoskeletal listings must be measured in terms of passive ROM—meaning

measured when you relax and let a doctor move the joint for you. The only exception is the spine, for which you must actively participate in movements. Active range of motion is where you voluntarily move a joint, and most active ROM measurements are considered unreliable because they depend on applicants to honestly move their joints to the maximum degree when asked. Active ROM tests can lead to serious disagreements between you and the SSA. If you state that you cannot bend, but nothing through a physical test or x-ray verifies your claim, the SSA does not have to believe you. SSA evaluations frequently reveal (through physical examinations, x-rays and other laboratory tests) that applicants alleging incapacitating arthritis and inability to move joints actually have a good ROM and minimal abnormalities.

Rheumatoid factor (RF). Certain abnormal antibodies that the body has produced and are especially associated with rheumatoid arthritis. An abnormal RF may be associated with rheumatoid arthritis, but it is possible to have rheumatoid arthritis without testing positive. At the same time, you may test positive even if you don't have arthritis, so an abnormal result does not guarantee the presence of arthritis. RF is reported by laboratories as "positive" or "negative," and also as degrees of abnormality called *titers*. The higher the titer, the more times a sample of serum can be diluted and still give a positive reaction, and this suggests a more severe disease process. For example, an RF titer of 1:150 is positive at up to 150 dilutions while a titer of 1:500 is still positive when diluted 500 times.

Sacroiliac joints. Joints between the pelvic bones and the sacrum of the spine.

Scapula. Shoulder blade.

Scoliosis. Abnormal lateral curvature of the spine.

Sensory nerves. Nerves that transmit sensory information (touch, pain, cold, etc.) from the body to the spinal cord and up to the brain.

Septic arthritis. Infection of the bones of a joint.

Soft tissues. Nonbony tissues such as muscles, nerves, blood vessels, lymphatic vessels, ligaments and tendons.

Spinal stenosis. Narrowing of the spinal canal (protected space inside the spine containing the spinal cord and its nerve roots), usually as a result of arthritis.

Spine. Bony vertebrae stacked on top of each other and separated by intervertebral discs that permit some degree of cushioning and flexibility. The seven vertebrae of the neck (C1-C7) are called the cervical spine. The 12 vertebrae in the chest are the thoracic spine (T1-T12), while the five vertebrae in the lower back are known as the lumbar spine (L1-L5). Beneath the lumbar spine is the sacrum, which consists of a triangular piece of bone of sacral vertebrae fused together (S1-S4). At the end of the spinal column is the tail-bone (coccyx). The vertebrae forming the spine are overlaid and connected by many spinal muscles and ligaments. They also form small joints between each other called facet joints.

Definitions (continued)

Spondylolisthesis. Forward subluxation of a vertebra, most commonly of the fifth lumbar (L5) over the next lower vertebra (first sacral, S1). Spondylolisthesis does not put pressure on nerve roots, and therefore does not cause neurological abnormalities such as muscle weakness, loss of sensation or reflex changes.

Straight leg raising (SLR) test. Testing a patient who is lying on his or her back by lifting the outstretched leg until the patient complains of pain. The SLR is used to detect pressure on spinal nerve roots such as could be caused by an HNP, tumors, bone spurs and the like. In people of normal health, the leg can be lifted 80 or more without pain. An SLR test should not be considered positive if leg movement is limited by tight hamstring tendons behind the knee. Back pain shooting down the leg during SLR is stronger evidence of nerve root compression than back pain alone.

Stump. Remaining length of leg after amputation.

Subcutaneous nodules. Lumpy abnormalities of tissues beneath the skin that are sometimes associated with rheumatoid arthritis.

Subluxation. Slippage of bones out of normal relation to each other—dislocation.

Synovial membranes. Membranes that surround and help lubricate joints; they become inflamed and tender in active rheumatoid arthritis.

Systemic. Affecting the body as a whole.

Tarsal bone. Any ankle bone.

Tendons. Cable-like, flexible, tough connective tissue strands that anchor muscles to bones. Muscles pull on tendons to move bones.

Thoracic spine. Spine area in the chest.

Tibia. Large bone in the front of the leg, commonly known as the shin bone. The upper end of the tibia forms the lower side of the knee joint, and the lower end of the tibia forms the joint with the ankle.

Ulna. Small bone in the forearm between the elbow and wrist, on the same side of the forearm as the little finger.

Ulnar deviation. Deformities of the fingers that severely limit use of the hands, usually found in rheumatoid arthritis and results in a sideways pointing of the fingers.

A. General Information

This chapter describes the disorders that affect the musculoskeletal system of the body, consisting of bones, muscles, tendons, ligaments and joints. Impairments of the musculoskeletal system are frequently seen by the SSA. The effect a particular disease has on the musculoskeletal system depends on the individual patient, as well as whether the disease is in an early or advanced stage. Musculoskeletal disorders can be hereditary, congenital, or acquired. The resulting impairments from various disorders can result from infections, inflammation, degenerative processes, trauma, tumors, blood vessel diseases, abnormal development and metabolic diseases.



The SSA accepts diagnosis of a disorder's severity only from medical doctors (M.D.s) and osteopaths (D.O.s).

Reports from chiropractors, nurses, physical therapists, naturopaths and others who don't have an actual license to practice medicine are evaluated but are not sufficient to establish disability.

1. Arthritis

Most allegations of disability involving musculoskeletal disorders are associated with arthritis. Examples of types of arthritis and diseases that can cause arthritis include the following:

- AIDS
- ankylosing spondylitis
- autoimmune diseases, such as systemic lupus erythematosus
- cancer
- infections—bacterial, fungal or viral
- inflammatory bowel diseases, such as ulcerative colitis and regional enteritis (Crohn's disease)
- metabolic diseases, such as gout and pseudogout
- osteoarthritis
- psoriasis
- Reiter's syndrome, and
- rheumatoid arthritis.

To the extent that inflammation of soft tissues in joints or the spine is involved, evaluation would be done under the Immune System Listings 14.09 and 114.09. Some musculoskeletal disorders, such as rheumatoid arthritis of joints and ankylosing spondylitis of the spine, can produce both soft tissue inflammation and bony damage. It may be necessary to evaluate such disorders under more than one of the SSA's listings.

2. Traumatic Damage

Most traumatic damage seen by the SSA comes from automobile, motorcycle and industrial accidents. Major trauma may fracture multiple bones, including the spine, rupture organs, amputate limbs, tear away skin and muscle, damage

joints, crush or sever the spinal cord with resulting paralysis or fracture the skull with permanent brain injury.

3. Back Pain

Most back pain is caused by age-related degenerative processes like degenerative disc disease and arthritis. Other, less common, causes of back pain include inflammatory diseases (ankylosing spondylitis) and cancer (such as breast or prostate cancer) that has spread to the spine. Medical judgment must be used in evaluating each case in regard to severity and chances for improvement.

4. Amputations

Amputations can result from trauma itself, or be required as surgery to remove a limb that has been too badly damaged to repair after trauma. Most amputations seen by the SSA, however, result from surgery to remove a diseased leg to which adequate blood flow cannot be restored—usually as a consequence of diabetes. Atherosclerosis can also lead to a diseased leg requiring amputation. In these instances, however, modern surgical techniques can often restore blood flow sufficiently to avoid amputation.

5. Other Diseases

Several genetic diseases, such as muscular dystrophy, affect muscle strength. Inflammatory muscle diseases, such as polymyositis, can cause muscle weakness but are discussed in Chapter 29. Neurological disorders such as strokes, cerebral palsy and polio can also cause muscle weakness and are discussed in Chapter 26. Muscle strength also may be decreased by chronic use of drugs such as steroids and alcohol—an added factor in severity that must be considered in all cases.

6. Loss of Function

Loss of function is vitally important in determining the extent of disability caused by musculoskeletal disorders. Although a physical examination and x-rays must reveal objective abnormalities, your inability to function, particularly due to pain, fatigue or other symptoms, is equally as important. Of course, saying that you're feeling pain or other symptoms if you don't also have physical abnormalities that would reasonably explain such symptoms may be given little credibility in a disability determination. The SSA needs evidence from your treating doctor to support your claim of disability. Unfortunately, a treating doctor's records often do not contain sufficient details about alleged musculoskeletal disorders for the SSA to make an accurate disability

determination. In fact, the records of many treating doctors report disorders that cannot possibly be present based on physical examinations and x-rays. You may very well have to undergo a consultative examination or have x-rays or other tests through the state DDS.

Unless you have some obviously irreversible impairment, such as an amputation or degenerative arthritis, the SSA will need multiple examinations to determine if your condition is going to last 12 months. This is particularly true in soft tissue injuries. Your treating doctor's records can help show that the findings have been present for some time. If you have no treating doctor records, the SSA would have you examined at its expense, wait at least three months and have you examined again after you have been treated.

Loss of function may be due to bone or joint deformity or destruction from any cause; miscellaneous disorders of the spine with or without neurological deficits; amputation; or fractures or soft tissue injuries including burns that require prolonged periods of immobility or convalescence.

a. Pain or Other Symptoms

Pain or other symptoms may be an important factor contributing to functional loss. The musculoskeletal listings that include pain or other symptoms among their criteria also include criteria for limitations caused by pain.

b. How the SSA Defines Loss of Function

Regardless of the cause of a musculoskeletal impairment, functional loss refers to an (1) inability to walk effectively on a sustained basis, or (2) inability to perform fine and gross movements effectively on a sustained basis. The SSA will consider whether your daily activities are consistent with the exam findings reported by your doctor, or with a consultative examination. In children, function should always be looked at in terms of what is appropriate for the child's age. In older teenagers, age-appropriate function can be similar to that of an adult.

If you feel that you cannot return to your prior job, supporting statements from supervisors or co-workers can be helpful in verifying your work-related limitations. These are people who have seen your work-related difficulties first-hand. Your own statements and those of your family members can also help complete the picture of your limitations for the SSA. In children, limitations at school, at home, and at play can help the SSA establish the severity of their functional loss.

If you are an adult, detailed information about your functional limitations can be critical in determining your residual functional capacity—which, in turn, is important in

the SSA's decision whether you will be allowed benefits on a medical-vocational basis.

7. Diagnosis and Evaluation

Diagnosis and evaluation of your musculoskeletal impairments should be appropriately supported by detailed descriptions of your joints, including ranges of motion. Additionally, the report on the condition of your muscles should discuss the presence of any weakness or atrophy. Any abnormal sensation or reflexes, decreased circulation, and laboratory findings should be described. Findings on your x-rays or other appropriate imaging may be used in making a disability determination. Medically acceptable imaging includes:

- plain x-ray imaging
- computerized axial tomography (CAT scan)
- magnetic resonance imaging (MRI)
- myelography, and
- radionuclear bone scans.

The SSA tries to avoid buying expensive tests for you such as MRIs, and will never purchase invasive tests such as myelography. However, such tests can be extremely useful when provided by your treating doctor. Also, if you've had any surgical procedures done, be sure your documentation includes a copy of the operative notes and any available pathology reports.

8. Orthotic, Prosthetic or Assistive Devices

If you use an orthosis, the SSA will want your medical exam data to include an evaluation of your maximum ability to function with the orthosis in place. Normally, the SSA will not require that you be evaluated for ability to function without your orthosis. However, if you state that you cannot use an orthosis, the SSA will want the reason documented and your ability to function without it evaluated by a doctor who actually examines you. An exception would be made if the doctor can put forth a reasonable medical explanation of why you cannot be evaluated without your orthosis.

If you use a prosthesis, the SSA will want you to have a medical exam with the prosthetic device in place. Of course, if you have an amputation, the SSA will not require an evaluation of your ability to walk without a leg prosthesis. However, the SSA will require that the condition of the stump be described. This is important, because some claimants have ulcers, infection or other problems that can cause short- or long-term problems in wearing the prosthesis.

If you use a hand-held assistive device such as a cane, crutch or walker, you will be examined both with and with-

out the device unless this goes against the medical judgment of a doctor who has treated or examined you. Your ability to walk with and without the device provides information about how well you can ambulate without assistance. The SSA tries to document the medical basis, such as instability of a joint or muscle weakness, for the use of any assistive device.

The requirements are similar for evaluating children with orthotic, prosthetic or other devices, except that evaluation must be done based on age-appropriate expectations for the particular child.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 1.02: Major Dysfunction of a Joint (Adults)

This listing relates to severe functional loss caused by any type of joint dysfunction, regardless of the specific medical diagnosis. For example, the problem could have been caused by trauma or by any of the many types of arthritis. Trauma resulting from industrial, automobile and motorcycle accidents accounts for most of the traumatic cases seen by the SSA. Severe traumatic bone fracture into a joint space is often followed by post-traumatic degenerative arthritis after the fracture is healed. Inflammatory processes, such as rheumatoid and psoriatic arthritis, can eventually lead to bone destruction and joint deformity if not adequately controlled with treatment. So, by the time gross deformity of a joint is present, there usually has been a joint disorder present for quite some time.

a. Listing Level Severity

First, the listing requires you to have an obvious (gross) deformity. Possible examples of such deformity are subluxation, contracture, ankylosis and instability. You must also have a history of chronic joint pain and stiffness, as well as

loss of motion or some other kind of abnormal movement. In addition, some type of imaging technique, such as x-rays, must verify the presence of arthritic changes such as joint space narrowing. A particular percentage of joint space narrowing or other abnormality is not required.

Once it's been established that your condition meets the requirements above, your condition must be shown to satisfy ④ or ⑤, below.

④ Involvement of one hip, knee or ankle joint that results in extreme limitation in your ability to walk. You must be unable to sustain a reasonable walking pace over a sufficient distance to carry out your activities of daily living. You should be unable to travel without a companion's assistance to and from your job or school. More specifically, some examples of ineffective ambulation given by the SSA include your:

- inability to walk without the use of a walker
- inability to walk without the use of two crutches or two canes
- inability to walk a block at a reasonable pace on rough or uneven surfaces
- inability to use standard public transportation
- inability to carry out ordinary activities involving walking, such as shopping and banking, and
- inability to climb a few steps at a reasonable pace with the use of a single hand rail.

The listing does not require complete inability to walk in all circumstances. For example, if you can walk about your home without the help of a person or an assistive device, that does not, by itself, mean you cannot qualify under the listing. The requirement is that you have serious difficulty in starting, sustaining or completing activities. Also, using only one crutch or cane would not necessarily restrict you from qualifying under the listing, provided that your functional limitations are severe enough. In addition, the SSA recognizes that people who cannot walk effectively might be able to stand without assistive devices. Therefore, your ability to stand without assistance would not disqualify you under the listing.

⑤ Involvement of one major joint *in each upper extremity* that results in extreme limitation in your ability to perform fine and gross movements. Major joints are the shoulder, elbow or hand-wrist.

To use your upper extremities effectively in carrying out your activities of daily living, you must be able to perform such functions as reaching, pushing, pulling, grasping, and fingering. Therefore, examples of inability to perform fine and gross movements effectively include, but are not limited to, an inability to prepare a simple meal and feed yourself, inability to take care of personal

hygiene, inability to sort and handle papers or files and an inability to place files in a file cabinet at or above waist level.

To qualify under part ⑤, it is not necessary that you have a *total* inability to use your upper extremities. The requirement is that you have serious difficulty in starting, sustaining or completing activities.

b. Residual Functional Capacity

In analyzing residual functional capacity, the SSA divides your body in two, analyzing your upper extremities separately from your lower extremities.

i. Upper Extremity Dysfunction

The SSA needs information regarding how well you can use your upper extremities—specifically, whether you're able to push, pull, lift, carry and grasp objects and do small movements with your fingers (fine manipulations). Think of all the things you cannot do because of pain, deformity or fatigue. Can you pick up coins? Easily grasp and turn door-knobs? Open jars? If you were unable to perform prior work because of arthritis, exactly how did the arthritis interfere? Specific examples of why you can no longer perform the job are much better than vague generalizations such as, "I was in pain" or "My arthritis bothered me." For instance, how much weight can you lift and carry? Did pain limit the use of hand controls necessary for working? Exactly how? Include environmental factors: Arthritis that is tolerable working in normal temperatures might be limiting in the cold. If you have significant arthritis in your shoulder, pain will probably limit the amount of overhead work you can do. Shoulder, elbow, or hand arthritis will limit how much pushing and pulling you can do.

Note that the use of an assistive device such as a cane ties up the use of an arm and hand. So, if you require a cane to walk, the SSA cannot refer you to jobs requiring that you lift and carry with both arms while walking.

ii. Lower Extremity Dysfunction

In evaluating your RFC, the SSA must determine how long you can stand and walk on arthritic joints. Let the SSA know if the arthritis is severe enough that you can't stand or walk most of a workday—and have your treating doctor provide supporting statements. For the SSA to claim that you can perform light, medium or heavy work, you must be able to walk or stand six to eight hours a day. Significant arthritis in a major joint of a lower extremity would prevent such standing or walking. Even if your hands and

arms are unaffected by the arthritis, you'll be restricted to sedentary work. If you are older and have a limited education, these restrictions may mean that you'll be awarded benefits on the basis of the RFC.

If you had an arthritic hip, knee or ankle joint replaced with an artificial one, see the RFC comments under Listing 1.03.

2. Listing 101.02: Major Dysfunction of a Joint (Children)

First, the listing requires that the child have an obvious (gross) deformity. Possible examples of such deformity are subluxation, contracture, ankylosis and instability. The child must also have a history of chronic joint pain and stiffness, as well as loss of motion or some other kind of abnormal movement. In addition, some type of imaging technique, such as x-rays, must verify the presence of arthritic changes like joint space narrowing. The child doesn't need to have any specific percentage of joint space narrowing or other abnormality.

Once it's been established that the child's condition meets the requirements above, the condition must also be shown to satisfy **A** or **B**, below.

A Involvement of one hip, knee or ankle joint that results in extreme limitation in the child's ability to walk. The child must be unable to sustain a reasonable walking pace over a sufficient distance to be able to carry out age-appropriate activities of daily living.

For children who are too young to be expected to walk independently, the SSA considers their function in terms of how well they can perform age-appropriate activities with their lower extremities. For such children, an extreme level of limitation means skills or performance at no greater than one-half of age-appropriate expectations based on an overall developmental assessment rather than on one or two isolated skills.

Older children would not have the ability to travel without a companion's assistance to and from a job or school. More specific examples of ineffective ambulation given by the SSA include the older child's inability to:

- walk without the use of a walker
- walk without the use of two crutches or two canes
- walk a block at a reasonable, age-appropriate pace on rough or uneven surfaces
- use standard public transportation
- carry out ordinary age-appropriate activities involving walking, such as shopping and school activities, or
- climb a few steps at a reasonable pace with the use of a single hand rail.

The listing does not require that the child be completely unable to walk in all circumstances. For example, the child's ability to walk about its home (or short distances at school) without the help of a person or an assistive device does not, in and of itself, mean the child cannot qualify under the listing. The requirement is that the child have serious difficulty in starting, sustaining or completing activities. Nor would the use of only one crutch or cane necessarily restrict the child from qualifying under the listing, provided that his functional limitations are severe enough. Also, the SSA recognizes that people who cannot walk effectively might nevertheless be able to stand without assistive devices. Therefore, the child's ability to stand without assistance would not disqualify him or her under the listing.

B Involvement of one major joint *in each upper extremity* that results in extreme limitation in the child's age-appropriate ability to perform fine and gross movements. Major joints are the shoulder, elbow or hand-wrist.

For very young children, the SSA will look at how limited they are in their ability to perform age-appropriate activities involving the upper extremities. Determinations of extreme limitation in such children are made by

comparison with the limitations for persistent motor dysfunction for infants and young children described in Listing 110.07A.

For an older child to use his upper extremities effectively in carrying out age-appropriate activities of daily living, the child must be able to perform age-appropriate functions like reaching, pushing, pulling, grasping and fingering. Therefore, in older children, examples of inability to effectively perform fine and gross movements include inability to prepare simple meals and feed themselves, inability to take care of personal hygiene and inability to sort and handle papers or files (depending on which activities are age appropriate).

To qualify under part B, it is not necessary that the child be *totally* unable to use his upper extremities. The requirement is that they have serious difficulty in starting, sustaining, or completing age-appropriate activities.

3. Listing 1.03: Reconstructive Surgery on a Hip, Knee or Ankle (Including Surgical Arthrodesis of a Joint) (Adults)

Reconstructive surgery usually involves placing an artificial joint into a person. An alternative procedure is surgical arthrodesis—fusing an arthritic joint with healthy, living bone to relieve pain and make it more stable. In most cases, reconstructive surgery is successful. Patients are able to put at

least partial weight on the joint and walk within a few days, and to put full weight on the joint soon after that. Certainly, walking usually occurs within a year of surgery. Only in cases of surgical failure—such as a loose artificial joint or infection of the bone—is the patient likely to remain unable to walk. Even then, a second operation usually corrects the problem.

Your surgeon may try to help you by reporting to the SSA that “recovery will require a year” in the absence of any documented complications. However, these kinds of statements are likely to be disregarded by the SSA if the surgeon cannot provide evidence to back it up.

a. Listing Level Severity

To qualify, you'll need to show the failure of reconstructive surgery on your hip, knee or ankle and that you'll be unable to walk effectively on the joint for at least 12 months. See the discussion under Listing 1.02A regarding how the SSA decides whether walking is ineffective.

b. Residual Functional Capacity

If you had an arthritic hip, knee or ankle joint replaced with an artificial one, you will still have some limitations. You should not be expected to work in a setting where you'd be walking on grossly uneven surfaces or climbing or using leg controls more than occasionally. Similarly, you should probably be restricted to no more than light lifting, up to 20 pounds. If your artificial joint has problems or you have had artificial joint replacements in multiple major weight-bearing joints, your RFC rating should not be higher than sedentary work. However, the SSA has no official policies in regard to how much a person with a prosthetic joint can lift and carry. Of course, if you are restricted to sedentary work because of an inability to walk over two hours daily, you wouldn't have to lift over ten lbs anyway.

If you have a solid arthrodesis in a joint, the SSA could give you a RFC for as high as medium work. Remember that an arthrodesis, unlike a prosthesis, will fix a joint so that it cannot bend. This can limit you from certain kinds of work-related activities. For example, a fused knee joint will prevent use of leg controls with that leg. It will also rule out various activities such as squatting, kneeling and climbing anything more than a slight incline.

4. Listing 101.03: Reconstructive Surgery on a Hip, Knee or Ankle (Including Surgical Arthrodesis of a Joint) (Children)

See comments under adult Listing 1.03.

a. Listing Level Severity

Failure of reconstructive surgery of the child's hip, knee or ankle with an inability to walk effectively on the joint expected to last at least 12 months. See the discussion under Listing 101.02 regarding how the SSA decides whether walking is ineffective in a child.

5. Listing 1.04: Disorders of the Spine (Adults)

This listing deals with various spinal disorders common in adults, such as:

- herniated nucleus pulposus (HNP)
- spinal arachnoiditis
- spinal stenosis
- osteoarthritis
- degenerative disc disease
- facet arthritis, and
- vertebral fracture.

(Note that inflammatory disorders involving the spine, known as spondyloarthropathies, are evaluated under Listing 14.09. Examples of disorders that can cause spondyloarthropathy are ankylosing spondylitis and Reiter's syndrome.)

The SSA requires that your spinal exam include testing your reflexes, sensation and muscle strength. Additionally, your exam should test your ability to squat and arise, walk on your heels and toes and bend your back. The presence or absence of muscle spasms in your back should be noted, as this is an objective finding that lends credibility to lower back pain complaints. Weakness, as well as reflexes and sensation, must rationally relate to the nerve root that is compressed. (Specific nerves supply specific muscles and carry sensation from specific areas of skin.) If you have muscle atrophy, there must be measurements of your muscles, documenting the degree to which they have actually gotten smaller. Weakness should be graded on a scale of zero to five. The examining doctor will be asked to add any other relevant observations about you, such as your ability to get on and off an examining table and whether you need help putting on your socks and shoes, or slacks or trousers.

The SSA will also evaluate the restrictions on your daily activities. If you allege marked limitations in your daily activities because of pain but have not seen your treating doctor, be prepared to explain why not. If your treating doctor's records are incomplete or not current, the SSA will send you for a consultative examination.

Because pain is the factor that most limits the activities of claimants with back disorders, it is important that you have a fairly good grasp of how the SSA looks at back pain. The

SSA cannot directly measure your actual pain level. By evaluating your behavior, however, the SSA can get a general picture of your pain. Even if you don't meet this listing, evaluation of your pain will become the main consideration in determining your residual functional capacity.

A person in really severe pain tries to obtain relief. The SSA will look at how often you go to the doctor for your pain, what your doctor says about the pain and the medical records showing your history of severe pain. If you have transportation or money problems that limit your ability to obtain the best treatment, make that clear to the SSA. Be aware that the SSA may check such an assertion with your treating doctor.

The SSA will look at the types of treatments your doctor has administered or recommended to treat the pain, and at how you responded. The treatments may help indicate the degree of your pain—at least as your doctor has understood it—and show how well you responded. Possible pain treatments include pain relievers, muscle relaxants, physical therapy, braces, epidural steroid injections, transcutaneous electrical nerve stimulators (TENS), biofeedback, psychotherapy, spinal cord electrical stimulators, treatment in special pain clinics and treatment with radio-frequency fields to damage pain fibers in the facet joints that connect vertebrae. (See Chapter 5 for more information about pain and other symptoms.) If you have prominent neurological abnormalities, evaluation should also be done under the appropriate neurological listing.

a. Listing Level Severity

Once a disorder has been documented, your condition must satisfy either (A), (B), or (C), below.

(A) Evidence of pressure on your spinal nerve root or spinal cord, as evidenced by:

- pain
- loss of motion in the spine
- muscle weakness
- decreased deep tendon reflexes and sensation, and
- an abnormal straight-leg-raising test, if the lower back is involved.

This part of the listing is quite difficult to satisfy, as most cases of back pain are not associated with significant neurological abnormalities.

(B) Spinal arachnoiditis, as evidenced by:

- confirmation of the disorder by a pathology report of a biopsy, an operative note confirming arachnoiditis, or an appropriate imaging test (myelography, CT scan or MRI)
- severe burning pain, or other abnormal and painful sensation (dyesthesia), and

- pain severe enough to require changing your position or posture more than once every two hours.

(C) Lumbar spinal stenosis resulting in pseudoclaudication, as evidenced by:

- an appropriate imaging test (myelography, CT scan or MRI), and
- chronic nonradicular pain and weakness that results in your being unable to walk effectively.

To read about how the SSA defines being unable to walk effectively, see the discussion under Listing 1.02A.

b. Residual Functional Capacity

Most of the work-related limitations for back impairments are for pain caused by sitting or standing for prolonged periods, as well as lifting and bending. The majority of disability claimants seen by the SSA for back pain have some osteoarthritis of the spine or degeneration of the intervertebral discs, or have had a single back surgery. They are usually assigned an RFC for medium or light work with occasional bending. They may be granted disability, especially if they are over age 55, have a limited education and cannot return to their prior work.

You should receive an RFC rating for no more than medium work, even lower if you suffer any of the following impairments:

- lumbar fusion (bending should be restricted to occasional)
- cervical fusion (overhead work should be restricted to occasional)
- scoliosis of the thoracic or lumbar spine with at least 40° of scoliotic curve
- at least 50% compression fracture of a vertebral body
- significant spondylolisthesis associated with chronic pain
- significant osteoporosis of the spine
- significant degenerative disc disease in the cervical or lumbar spine with associated chronic pain
- chronic pain after a lumbar or cervical laminectomy, or
- significant degenerative arthritis of the spine with associated chronic pain.

Some claimants with multiple back surgeries or other severe back problems have so much pain that they cannot do even sedentary work, even though they don't have severe neurological abnormalities. These cases are exceptions, but they do occur. For example, pain might keep you from being able to stand long enough to do light work. But then severe pain would also prevent you from sitting for long enough to do sedentary work (about two hours). Instead, you would have to frequently alternate sitting and standing.

In such an instance, you would qualify for a medical-vocational allowance by RFC regardless of your age. In fact, this is the only way some claimants with incapacitating back pain can qualify for benefits. However, such cases are rare and require convincing evidence of a very severe back impairment, along with marked pain. This is difficult to document for claimants who do not see their treating doctor. Actually, most claimants with pain this severe have arachnoiditis and can be allowed under part ⑥ of the listing.

One final note: A disability applicant who appears to live a life of extreme pain with no physical impairment may be asked by the SSA to undergo a mental examination.

6. Listing 101.04: Disorders of the Spine (Children)

Arthritis and degenerative disc disease do not occur as often in children as adults. It's rare, for example, to see a herniated nucleus pulposus or spinal stenosis in a child. Nor is arachnoiditis seen as often in children as in adults. Traumatic fractures may be seen in children as well as adults. However, there are other spinal disorders that the SSA mentions with regard to children, such as:

- infection of the spine (vertebral osteomyelitis)
- metabolic disorders that weaken the spine
- developmental disorders resulting in incomplete or abnormal formation of the spine, or
- disorders of spinal curvature (scoliosis, kyphosis, kyphoscoliosis) that may appear alone or in association with some other disorder.

a. Listing Level Severity

Actually, a spinal disorder of any cause can qualify under the listing, provided that it produces the required abnormalities. The same kinds of physical examination abnormalities are required as for adults (see adult Listing 1.04A), taking into account the child's age. If the child has prominent neurological abnormalities, evaluation should also be done under the appropriate neurological listing.

7. Listing 1.05: Amputation (Adults)

Trauma, diabetes mellitus and atherosclerosis are the most common causes of lower-extremity amputations in adults. Most upper-extremity amputations are related to trauma, such as industrial accidents. However, the cause of the amputation is irrelevant—it is the functional result that matters to SSA. This fact is reflected in the requirements of the listing.

a. Listing Level Severity

Once the fact of your amputation has been documented, you must show that your condition satisfies ①, ②, ③ or ④ below.

- ① Amputation of both hands.
- ② Amputation of one or both lower extremities at or above the ankle and an inability to walk effectively, as described in Listing 1.02A.
- ③ Amputation of one hand and one lower extremity at or above the ankle, along with an inability to walk effectively, as described in Listing 1.02A. The SSA generally considers ineffective walking as that which ties up both hands in the use of assistive devices—such as two canes, two crutches, or a walker. Part ③ is an exception to this general rule, because the claimant has the use of only one upper extremity due to the amputation of a hand.
- ④ Hemipelvectomy or hip disarticulation. These types of surgery are so functionally limiting that once you've proven the surgery took place, nothing else is required. The resulting functional limitation can be assumed. A hemipelvectomy is even more extensive than a hip disarticulation, because it involves the additional removal of some pelvic bones.

b. Residual Functional Capacity

Few disability applicants have problems severe enough to qualify for this listing level. But many have some degree of damage to the legs that requires an RFC. These are evaluated case by case, but some of the frequently used RFCs are as follows:

- sedentary work for an above-the-knee amputation when you can walk effectively on an artificial leg, or
- medium work for a below-the-knee amputation when you can walk effectively on an artificial leg.

You would also face restrictions on walking on uneven surfaces, climbing, kneeling, crawling and using leg controls. In most instances, working at unprotected heights (such as on roofs or other structures requiring good balance to keep from falling) would also be restricted.

8. Listing 101.05: Amputation (Children)

In children, the cause of most upper- and lower-extremity amputations is trauma. In some cases, amputation of a limb may be necessary to treat a cancerous tumor, such as an osteosarcoma. Amputations are also done, though rarely, to treat an irreversibly deformed limb. However, the cause of the amputation is irrelevant—it is the functional result that matters to the SSA. This fact is reflected in the requirements of the listing.

a. Listing Level Severity

Once the fact of the child's amputation has been documented, the condition must satisfy Ⓐ, Ⓑ, Ⓒ or Ⓓ, below.

- Ⓐ Amputation of both hands.
- Ⓑ Amputation of one or both lower extremities at or above the ankle, along with an inability to walk effectively, as described in Listing 101.02A.
- Ⓒ Amputation of one hand and one lower extremity at or above the ankle, along with an inability to walk effectively, as described in Listing 1.02A. The SSA generally considers ineffective walking as that which ties up both hands in the use of assistive devices—such as two canes, two crutches or a walker. Part Ⓒ is an exception to this general rule, however, because the claimant has the use of only one upper extremity due to the amputation of a hand.
- Ⓓ Hemipelvectomy or hip disarticulation. These types of surgery are so functionally limiting that once you've proven the surgery took place, nothing else is required. The resulting functional limitation can be assumed. A hemipelvectomy is even more extensive than a hip disarticulation, because it involves the additional removal of some pelvic bones.

9. Listing 1.06: Fracture of the Femur, Tibia, Tarsal Bone or Pelvis (Adults)

The SSA frequently sees applicants with recently broken bones, but many are denied benefits because the breaks are expected to heal well within 12 months. This is true even for people with multiple fractures from automobile or motorcycle accidents. Only in rare cases where an applicant has a history of fractures not healing would the SSA predict that the current fractures would not heal within 12 months.

In general, for you to be granted disability on this basis, your fracture would have to remain unhealed for least six months and be likely to remain unhealed for a total of at least 12 months. Lack of healing for six months is not an SSA policy—but as a matter of medical fact, no doctor can reliably assert that the required 12-month duration will be satisfied without first seeing at least six months of failed healing. If your doctor states to the SSA that your fracture will not heal within 12 months, your doctor must provide supporting evidence. A simple letter stating that recovery from your fracture will require at least 12 months, without convincing medical reasons, will be almost useless.

a. Listing Level Severity

In addition to documentation of the fracture, your condition must qualify under both Ⓐ and Ⓑ, below.

- Ⓐ Solid union of your fracture is not evident on appropriate medically acceptable imaging and the fracture is not clinically solid. To satisfy the listing, an x-ray or other imaging test such as a MRI must confirm the failure of your fracture to heal. The x-ray must show that the space of the fracture line is still visible with little or no healing bony callus having formed across it. If the fracture is in a bone that can be evaluated on physical examination, then a doctor must feel or see movement evidence that the bone portions haven't reunited. Some healing of the fracture won't disqualify you as long as a solid union has not occurred.
- Ⓑ An inability to ambulate effectively, with no expectation that you'll regain your ability to walk effectively within 12 months of onset. The ability to walk effectively is described in Listing 1.02A.

b. Residual Functional Capacity

The extent of your RFC depends on the severity and location of your fractures. That means that the analysis must be highly individualized. The fractures that are most likely to heal poorly are those involving multiple bone fragments, fractures into joint spaces and fractures complicated by infection. Fractures that occur into joint spaces of the lower extremities may result in post-traumatic arthritis that remains as a permanent impairment after the fracture has healed. Such arthritis in a knee, hip or ankle can greatly reduce your ability to stand or walk for long periods, or to use leg controls. If you can't stand or walk for at least six to eight hours daily, your RFC is reduced to sedentary work and your chances of receiving a medical-vocational allowance are greatly increased.

10. Listing 101.06: Fracture of the Femur, Tibia, Tarsal Bone or Pelvis (Children)

See comments under adult Listing 1.06.

a. Listing Level Severity

In addition to documentation of the fracture, the child's condition must qualify under both Ⓐ and Ⓑ.

- Ⓐ Solid union of the child's fracture is not evident on appropriate medically acceptable imaging and the fracture is not clinically solid. To satisfy the listing, an x-ray or other imaging test such as an MRI must confirm the failure of the fracture to heal. The x-ray must show that the space of the fracture line is still visible with little or no healing bony callus having formed across it. If the fracture is in a bone that can be evaluated on physical ex-

amination, then a doctor must feel or see movement evidence that the bone portions have failed to reunite. Some healing of the fracture won't disqualify the child as long as it hasn't healed into a solid union.

- ⓑ An inability to ambulate effectively, with no expectation that the child will regain the ability to walk effectively within 12 months of onset. The ability to walk effectively is described in Listing 101.02A.

11. Listing 1.07: Fractures of an Upper Extremity (Adults)

The SSA frequently sees applicants with broken bones, but many are denied because the breaks are expected to heal well within 12 months. This is true even for people with multiple fractures from automobile or motorcycle accidents. Only in rare cases where an applicant has a history of fractures not healing would the SSA predict that the current fractures would not heal within 12 months. Allowances are made under this listing not merely because of the fracture itself, but because of the limiting effects of treatment and possible complications. The SSA may find that the listing is met based on your symptoms, signs, and laboratory findings from any recent or anticipated surgical procedures and post-surgery recuperative periods. The SSA should also consider any related medical complications, such as infections, illnesses, and therapies that will impede or delay the efforts toward restoration of function of your upper extremity.

In general, for you to be granted disability under this condition, your fracture would have to remain unhealed for least six months and be likely to remain unhealed for a total of at least 12 months. Lack of healing for six months is not an SSA policy—but as a matter of medical fact, no doctor can reliably assert that the required 12-month duration will be satisfied without first seeing at least six months of failed healing. If your doctor states to the SSA that your fracture will not heal within 12 months, the doctor must provide supporting evidence. A simple letter stating that recovery from a fracture will require at least 12 months, without convincing medical reasons, will be almost useless.

a. Listing Level Severity

To meet the required severity level under this listing, you must have a fracture of an arm bone (humerus) or of the forearm bones (radius or ulna) that has not healed, be under the continuing care of a surgeon who is treating you with the intention of restoring use of the arm and be unlikely to recover within 12 months of the date of the fracture.

The requirement that you be “under continuing surgical management” means that you should be receiving surgical

procedures and other associated treatments directed toward the salvage or restoration of functional use of the affected part. Restoration of function may be delayed by post-surgical procedures, surgical complications, infections, or other medical complications, related illnesses or related treatments.

If you have not experienced any significant changes for six months after your last definitive surgical procedure or other treatment, the SSA will assume that you've reached your maximum therapeutic benefit and will then evaluate your remaining condition. At that point in time, since the listing requires that you be under active surgical management to restore function, the listing can no longer be satisfied.

b. Residual Functional Capacity

The RFC depends on the severity and location of the fractures and therefore must be highly individualized. The fractures most likely to heal poorly are those involving multiple bone fragments, fractures into joint spaces and fractures complicated by infection. Although upper extremity fractures won't affect your ability to stand or walk, your RFC could be reduced by the effect of your impairment on the amount of weight you can lift and carry. For example, suppose you have a right arm fracture that involves the right shoulder joint and is healing poorly. Coupled with pain, you might have very little use of that arm for lifting. You also would not be able to use right arm controls or do any kind of overhead work with the right arm.

12. Listing 101.07: Fractures of an Upper Extremity (Children)

See comments under adult Listing 1.07.

a. Listing Level Severity

To reach the required level of severity under this listing, the child must have a fracture of an arm bone (humerus) or of the forearm bones (radius or ulna) that has not healed, be under the continuing care of a surgeon who is treating the child with the intention of restoring use of the arm and be unlikely to recover within 12 months of the date of the fracture.

Also see the comments under adult Listing 1.07.

13. Listing 1.08: Soft Tissue Injuries of an Upper or Lower Extremity, Trunk or Face (Adults)

Allowances are made under this listing not merely because of the injury itself, but because of the limiting effects of treatment and possible complications. Severe burns are a good example of an impairment that might be evaluated under this listing. A finding that the listing is met is based

on a consideration of the symptoms, signs and laboratory findings associated with recent or anticipated surgical procedures and the resulting recuperative periods. Included in this consideration should be any related medical complications, such as infections, illnesses and therapies that impede or delay the efforts toward restoration of function in your upper extremity.

In general, for you to be granted disability under this section, your injury would have to remain unhealed for least six months and be likely to remain unhealed for a total of at least 12 months. Lack of healing for six months is not an SSA policy—but as a matter of medical fact, no doctor can reliably assert that the required 12-month duration will be satisfied without first seeing at least six months of failed healing. If your doctor states to the SSA that the injury will not heal within 12 months, your doctor must provide supporting evidence. A simple letter stating that your recovery will require at least 12 months, without convincing medical reasons, will be almost useless.

Major function of the face and head relates to impact on any or all of the activities involving vision, hearing, speech, chewing (mastication) and swallowing.

a. Listing Level Severity

To meet the required level of severity under this listing, you must have soft tissue injuries that are undergoing multiple surgeries spread out over time. The surgeries must be intended to save one of your limbs from amputation or to restore a major function such as walking or using your hand. In addition, the surgery should not have restored or be expected to restore the major function within 12 months of the injury.

The phrase “under continuing surgical management” used in the listing refers to surgical procedures and other associated treatments directed toward the salvage or restoration of functional use of the affected part. Restoration of function may be delayed by post-surgical procedures, surgical complications, infections, or other medical complications, related illnesses or related treatments.

If you have not experienced any significant changes for six months after your last definitive surgical procedure or other treatment, the SSA will assume that you’ve reached your maximum therapeutic benefit level and then evaluate your remaining condition. At this point, since the listing requires that you be under active surgical management to restore function, the listing can no longer be satisfied.

b. Residual Functional Capacity

Your level of RFC will depend on the nature and severity of your individual injury. For example, if you are a young

claimant and have an amputated or nonfunctional arm and no planned surgery, you might be denied benefits based on your ability to perform one-armed light work with lifting of no more than 20 pounds. Even if you have some remaining function in an upper extremity, the SSA should pay close attention to your ability to grasp, push, pull and perform small (fine) manipulations with your fingers because these can have an important affect on your ability to work.

Lower extremity injuries that do not permit standing or walking six to eight hours a day will prevent heavy, medium and even light work. You could do no more than sedentary work that requires standing or walking no more than two hours daily. The SSA should consider your ability to walk with adequate balance, as well as climb and use leg controls.

14. Listing 101.08: Soft Tissue Injuries of an Upper or Lower Extremity, Trunk or Face (Children)

See comments under adult Listing 1.08.

a. Listing Level Severity

The listing requires the child to have soft tissue injuries that are undergoing multiple surgeries spread out over time, in which the surgeries are intended to save a limb from amputation or to restore a major function such as walking or using a hand. In addition, the surgery should not have restored or be expected to restore the major function within 12 months of the injury.

See comments under adult Listing 1.08.

15. Listing 100.02: Growth Impairment Related to Known Cause (Children)

Growth impairments linked to a definite medical cause include skeletal abnormalities like dwarfism, infections before birth, fetal alcohol poisoning, genetic abnormalities, diabetes, hypothyroidism, severe heart disease, sickle cell anemia, malnutrition, cystic fibrosis, kidney failure or other severe chronic diseases. Children who are small because their parents are small are not considered to have a growth impairment.

Growth in a child is considered normal when his height is within the range appropriate to the child’s age and sex. The SSA considers ranges of normality because there is no exact height that is normal for a child at a specific age and sex. Doctors refer to growth charts to determine if a child is growing properly. Growth is expressed as a percentile ranking regarding children’s height for age and sex. For

example, if a child is at the 50th percentile in height, then 50% of other children are taller and 50% are shorter. If a child is at only the third percentile in height, then 97% of all other children are taller. This strongly suggests the presence of a growth impairment.

a. Listing Level Severity

The listing requires a specific medical condition that causes the growth impairment. Additionally, the child's condition must satisfy Ⓐ or Ⓑ.

Ⓐ Sustained fall in height of greater than 15 percentiles.

This listing takes into account that a child who is not growing will have a fall in their percentile ranking of height as a result of increasing age, since older children are expected to be taller. For example, a child with a growth impairment who is in the 30th percentile at age six months will be at a much lower percentile at age one year if she doesn't grow. This listing is concerned with a *change* in a child's height as an indicator of growth impairment, rather than the child's actual percentile rankings in height.

Ⓑ Fall to, or persistence of, height below the third percentile. This listing is concerned with a child's actual percentile ranking in height being low enough to be diagnostic of a severe growth impairment.

For both parts Ⓐ and Ⓑ, a child would need to be measured at several different ages to satisfy the listing. If several height measurements are not available when the child applies for disability, the SSA will hold the claim for months until more measurements can be made.

16. Listing 100.03: Growth Impairment of Unknown Cause (Children)

Only children with growth impairments not related to some known medical disorder are evaluated under this listing.

Part Ⓐ is similar to part Ⓐ in Listing 100.02, except that a greater fall in percentile ranking for height is required. Part Ⓑ requires x-ray verification that the age of the child's bones are far below that normally expected for her age. This should be done by a doctor experienced in interpreting such x-rays—a radiologist. If the child's epiphyses (bone growth centers) are "closed," then they are no longer active and the child's growth has stopped. Such closure of the epiphyses is normal as a person becomes an adult and growth stops. In older children when the epiphyses have already closed at the time of disability determination, bone age determination can't be done and this listing cannot be used.

If several height measurements are not available when the child applies for disability, the SSA will hold the claim for months until more measurements can be made.

a. Listing Level Severity

To meet the required severity level, the child's condition must satisfy both Ⓐ and Ⓑ.

Ⓐ Sustained fall of greater than 25 percentiles.

Ⓑ Bone age greater than two standard deviations below the mean for chronological age. Before puberty, x-rays of the child's hand and wrist bones are sufficient. In older children, additional x-rays of a knee and ankle are required. ■

Chapter 17

Vision, Balance, Hearing and Speech

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Part I. Vision

Definitions

The following definitions are for words used in this section and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Accommodative reflex. Events that take place when you attempt to focus on an object brought near the eyes: the eyes converge (turn in the direction of the nose) and the pupils constrict (become smaller). Absence of an accommodative reflex is normal in children less than six months old; absence in older children suggests blindness.

Acuity. Ability to see clearly.

Amblyopia. Congenital eye disorder, characterized by decreased visual acuity in one or both eyes that otherwise appear normal to examination. Amblyopia results from the abnormal alignment of an eye (strabismus).

Anterior chamber. Space between the cornea and the iris.

Aphakia. Absence of the natural lens of the eye, usually a surgical removal because of a cataract or an injury to the eye.

Astigmatism. Irregularity in the surface of the cornea which can often be corrected with lenses.

Best-corrected visual acuity. The best acuity that can be obtained with refractive lenses. Your glasses or contact lenses do not necessarily produce best-corrected acuity. Best-corrected acuity can be determined either by an ophthalmologist or optometrist, and is a routine part of their examination. Best-corrected acuity testing must be done under standard conditions so that everyone's vision is measured the same way.

Bitemporal hemianopsia. Blindness in the outer halves of both the right and left visual fields. This kind of visual field loss occurs with pituitary tumors.

Blindness. A non-specific term meaning inability to see. See *statutory blindness*.

Cataract. Degeneration of the lens of the eye so that light cannot easily pass through it. Most cataracts are related to aging, but some date from birth (congenital cataracts) or from the use of medication, such as the chronic use of steroid drugs. Cataracts are sometimes described by doctors as a "lens opacity."

Central visual field. Central part of the visual field of each eye, related to the function of the macula.

Cornea. The clear, outer membrane of the eye through which light enters.

Corrected vision. Vision obtained after correction with refractive lenses.

Extraocular muscles (EOMs). Small muscles that attach to the outside of the eyeball and move it in different directions.

Fixation. Steady, focused gaze at a particular point or object.

Glaucoma. A serious and common eye disease, usually associated with increased fluid pressure inside the eye, which causes damage to the retina with progressive blindness if not treated medically or surgically. Glaucoma decreases both central and peripheral vision. Most cases of glaucoma are treatable, if diagnosed early.

Goldmann perimeter. An instrument for measuring the size of peripheral visual fields.

Hemianopsia (hemianopia). Blindness in half of the visual field of either eye or both eyes.

High myopia. Very severe near-sightedness. Unlike regular myopia, high myopia is associated with a risk of retinal damage and may cause blindness.

Homonymous hemianopsia. Blindness in the right half of the visual field in both eyes, or the left half of the visual field in both eyes.

Hyperopia. Far-sightedness resulting from the eyeball being too short, causing light to focus behind the retina, rather than on it. Near objects tend to be blurry.

Intraocular lens (IOL). An artificial lens surgically placed inside of the eye to replace a natural lens that is diseased with a cataract. Although the eye's natural lens is also within the eye—intraocular—the use of the phrase "intraocular lens" means an artificial lens.

Intraocular pressure (IOP). Pressure inside the eye, specifically in the anterior chamber right behind the cornea. Ophthalmologists and optometrists routinely measure intraocular pressures to detect elevated pressures that may be associated with glaucoma. Normal IOP is about 20 mm Hg or less, but a normal IOP for one person may be too high for another person. For example, one person may get glaucoma from an IOP of 21 mm Hg, while another suffers no ill effect. On the other hand, the risk of developing glaucoma would be very high for anyone with pressures of 25 mm Hg or more.

Iris. The pigmented (colored) eye muscle that controls the size of the pupil.

Lens. The natural lens is the part of the eye that permits you to focus on objects nearer than about 20 feet. Artificial lenses are intraocular lenses, glasses and contact lenses.

Lens opacity. Area in the natural lens blocking the transmission of light; a characteristic of cataracts.

Macula. Part of the retina that is responsible for color vision and central vision.

Macular sparing. Used in reference to visual field measurements to mean that visual pathways from the macula are unaffected by a disease process that has decreased other parts of the visual field. The importance of macular sparing is that central visual acuity is preserved.

Definitions (continued)

Meridians. The straight, spoke-like lines that intersect in the center of a visual field chart.

Myopia. Near-sightedness from the eyeball being too long, causing light to focus in front of the retina, rather than on it. Myopia can generally be corrected with glasses or contact lenses, but extremely severe cases can damage the retina to produce scotomas (see definition below). Extremely severe cases of myopia are called *high myopia* or *malignant myopia*.

Neovascularization. Excessive growth of new blood vessels in the retina; a serious complication of diabetes.

Nystagmus. Abnormal, rhythmic, oscillating movements of one or both eyes. The oscillations are usually in a horizontal direction, but may be vertical.

O.D. Oculus dexter, or right eye. It is a standard abbreviation associated with the examination of the eyes. In another context, O.D. also means *doctor of optometry*.

Ophthalmologist. A medical doctor (M.D.) or osteopath (D.O.) licensed to practice medicine and surgery, which includes diagnosing eye diseases, writing prescriptions for the treatment of eye diseases, measuring refractive errors and writing prescriptions for glasses or contact lenses. The SSA requires a disability diagnosis by an ophthalmologist or other medical doctor or osteopath. Medical diagnoses by optometrists, chiropractors or others not licensed to practice medicine are not used by the SSA to establish visual disability.

Ophthalmoplegia (total). Paralysis of the extraocular muscles that move the eyeball, the small ciliary body muscle that changes the shape of the eye's natural lens and the muscles of the iris that control the size of the pupil.

Optic atrophy. Degeneration of the optic nerve as a result of neurological disease, such as multiple sclerosis.

Optic chiasm. Location just behind the eyes where the optic nerves from each eye meet each other. It is in the optic chiasm that half of each optic nerve's fibers are mixed with those from the other eye.

Optic nerve. The bundle of approximately one million nerve fibers that carries visual information from each eye to the optic chiasm. The optic nerve head is that part of the optic nerve where it enters the back of the retina and can be seen on visual examination of the eye by a doctor.

Optic tract. Right and left bundles of visual nerve fibers leaving the optic chiasm. Each right or left optic tract carries half of the optic nerve fibers from each eye, after they cross in the optic chiasm. The right and left optic tracts enter the right and left cerebral hemispheres of the brain and carry visual information to the primary visual cortex in the back of the brain.

Optometrist (O.D.). A person qualified to measure refractive errors and write prescriptions for glasses and contact lenses. In some states, optometrists are permitted to diagnose glaucoma and write prescriptions for some medications used to treat glaucoma. Unlike ophthalmologists, optometrists are

not licensed to practice medicine. The SSA can use evidence from an optometrist concerning the testing of visual fields and measurement of visual acuity only if a medical doctor (M.D.) or osteopath (D.O.) first provides a medical diagnosis of an eye disorder.

Orbit. Bony space in the skull that holds the eye.

O.S. Oculus sinister, or left eye. It is a standard abbreviation associated with examination of the eyes.

Perimetry. Any technique that measures the size and shape of either central or peripheral visual fields.

Peripheral retina. Surrounds the macula and is responsible for peripheral vision.

Peripheral vision. Visual awareness of objects in the peripheral visual fields, without determining a specific acuity. Without peripheral vision, you would have tunnel vision, as if looking down a tube. A peripheral vision test measures your ability to see objects in your peripheral vision; it maps the size and shape of visual fields and scotomas (see definition below).

Peripheral visual fields. Outer parts of the visual fields.

Phthisis bulbi. A congenital malformation of the eye, consisting of shrinkage and wasting of the eyeball, and resulting in virtually complete blindness in the eye affected.

Posterior chamber. Space between the iris and the eye's natural lens.

Presbyopia. Decreased near acuity caused by stiffening of the natural lens of the eye as a result of aging. Most people by age 45 have presbyopia. Correctable with glasses.

Primary visual cortex. Area in the back of the brain that first receives visual information from the optic tracts.

Pseudophakia. An eye with an intraocular (artificial) lens.

Pupil. Circular hole in the iris that controls how much light enters the eye by changing size.

Red reflex. A diffuse red color reflecting from the retina when a doctor shines an ophthalmoscope into your eyes.

Refraction. Testing your vision with different kinds of lenses to learn the degree of refractive error and determine the types and strengths of lenses needed to obtain a best-corrected acuity.

Refractive error. Extent to which poor focusing of light on the retina is responsible for poor central visual acuity. Refractive lenses are used to correct central visual acuity. Non-refractive errors causing poor acuity, such as diabetic damage to the retina or degeneration of the macula, are not related to poorly focused light and cannot be corrected with lenses.

Refractive lenses. Glasses or contact lenses.

Retina. Light-sensitive layer of the back part of the eye that processes light information before transmission to the brain. The reaction of the retina to light is based on changes in retinal chemicals when hit by photons of light. Such chemical changes excite nerve fibers in the retina.

Retinal detachment. Tearing of the retina from its base.

Definitions (continued)

Retinal edema. Swelling in the retina caused by the build-up of excessive fluid.

Retinopathy. Any disease of the retina. The most common is diabetic retinopathy, which causes blindness. Diabetic retinopathy may consist of retinal edema due to leakage of fluid from damaged blood vessels, bleeding in the retina or retinal detachment. Diabetic retinopathy may also cause neovascularization (see definition above).

Retrolental fibroplasia. Retinal damage to an infant from exposure to an excessive duration and concentration of oxygen just after birth, often caused when trying to treat the infant for respiratory distress associated with premature lungs.

Sclera. White part of the outer eyeball.

Scotoma. Blind spot in the visual field.

Snellen chart. Chart containing rows of letters which grow smaller from top to bottom. The chart is viewed from a distance of 20 feet and the ability to read each row is associated with a particular visual acuity for distance.

Statutory blindness. A best-corrected central visual acuity for distance of 20/200 or worse, or a peripheral visual field that is reduced to 20 degrees or less diameter. Disability based on statutory blindness can increase the amount of monthly benefits and can convey other possible financial benefits. Also called *legal blindness*.

Strabismus. Abnormal alignment of one or both eyes ("lazy eye"). Such deviation of an eye can cause varying degrees of visual loss in an otherwise normal eye (see definition of amblyopia above).

Tangent screen. Device for measuring the size of central visual fields.

Visual acuity. Type of vision associated with the ability to see maximum detail. Visual acuity involves a small area of the retina called the fovea. Care must be taken not to confuse visual acuity for distance and visual acuity for near vision. It is distance acuity that is usually measured and of the most importance in determination of disability.

Distance acuity. Normal acuity for distance (more than about 20 feet away) is 20/20. The first number refers to the distance you have to be from a test object—such as letters on a Snellen chart—to see it; the second number is how far away a normal person has to be to see the same thing. If you have 20/20 acuity, it means you can see an object at 20 feet that a

normal person can see at 20 feet—you have normal distance acuity. If you have 20/200 vision, then your vision is much worse because you must be 20 feet from an object to see what a normal person can see at 200 feet. A decrease in distance acuity is near-sightedness (myopia) and should not be confused with near acuity, discussed below. Many people with poor distance acuity have good near acuity.

Near acuity. Visual acuity for near vision represents how well a person can see objects closer than 20 feet away, especially to read printed materials at about 14 inches. Near vision in adults is tested by the ability to read different-sized text; it is reported as a Jaeger number from J1 to J14. J1 is 14/14, normal vision, because you can see at 14 inches what a normal person can see at 14 inches. If you have 14/140 near vision, however, then text must be so large that what you can read at 14 inches a normal person could read at 140 inches. Problems with near vision are not nearly as disabling as those with decreased distance acuity. While near acuity may be a consideration in residual functional capacity, none of the listings involve near acuity.

Visual acuity efficiency. Determined by referring to tables that assign percentages to different central visual acuities.

Visual efficiency (VE). A calculation of overall visual loss in an eye by combining visual field efficiency and visual acuity efficiency. Obtained by multiplying the visual field efficiency by the central visual efficiency.

Visual evoked responses (VER). Measurements and computer analysis of electrical brainwaves produced in response to looking at a test pattern of light. Tests the health of the brain pathways involved in vision. It is completely safe and harmless.

Visual field efficiency (VFE). Percentage of remaining peripheral visual field in an eye.

Visual fields. Areas of vision in each eye in which vision occurs around the point of fixation—the kind of sight one has of something when not looking directly at it.

Vitreous. Clear, gel-like substance that fills the part of the eye between the lens and the retina. The vitreous makes up most of the weight of the eye. Bleeding of the retina into the vitreous is called a vitreous hemorrhage and is a serious complication of diabetes or trauma to the eye.

A. General Information

Decreased vision may result from many diseases, injuries or abnormal development of parts of the eye from before birth. The most common causes of adult visual impairments are uncontrolled diabetes, glaucoma, cataracts or macular degeneration. The most common causes of visual impairments in children are those dating from birth, such as congenital cataracts, retrolental fibroplasia and eye malformations like phthisis bulbi. Also, uncontrolled diabetes can cause retinopathy in children, just as it can in adults. In both children and adults, some drugs used to treat noneye diseases can damage the retina.

Visual loss can also occur with normal eyes, when there is damage to optic nerves, optic chiasm, optic tracts, other visual pathways deep in the brain or areas of the brain that deal with processing visual information. If you have increased difficulty with vision after suffering a stroke, brain tumor, multiple sclerosis or any other condition that can cause neurological damage, let your doctor and the SSA know so you can be properly tested.

Without at least a very basic knowledge of eye structures and functions, you will have difficulty understanding the listings in a way that is useful to you—that is, you will be unable to discuss your case with the SSA, much less know when the SSA is wrong. In an examination of your eyes, a doctor will evaluate extraocular muscle function by watching how the eyeball moves in the orbit; test for the red reflex and the accommodative reflex; measure intraocular pressure; and examine the sclera, cornea, iris, pupillary function, anterior chamber, posterior chamber, natural lens, retina and optic nerve head. The doctor will perform refraction to determine the extent to which your visual acuity can be improved. Refractive lenses can only improve poor vision caused by myopia, hyperopia, presbyopia and astigmatism—to the extent that vision is decreased by impairments such as cataracts, glaucoma, retinopathies or neurological disorders it cannot be helped with glasses or contact lenses. Visual field testing and visual evoked responses are not a part of routine eye examinations.

The SSA listings related to vision always involve the best-corrected vision in the better eye. You might forget your glasses if the SSA asks you to go to a consultative examination (CE) to have vision tested. This won't matter because best-corrected vision is measured with the lenses that are a part of the test, not with your own glasses. You might also allege blindness with the hope of qualifying for disability benefits. Some applicants claim they cannot see anything, including the largest letters on a Snellen eye chart or the

largest objects used to test visual fields. The SSA will reject such test results unless a medical doctor or osteopath provides objective information to the SSA showing that you have an eye or brain disorder reasonably capable of causing the alleged visual loss. For example, if you allege a degree of visual loss far worse than would be expected on the basis of eye examination and there is no documented nervous system impairment such as a stroke to explain your poor vision, the SSA may obtain a visual evoked response study on you to determine if the visual pathways in your brain are intact.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 2.02: Impairment of Visual Acuity (Adults)

This listing concerns distance vision—the ability to see objects at a distance, meaning farther away than 20 feet.

Blindness from any cause can qualify under this listing, with the exception of “hysterical blindness” which is a rare mental disorder.

The various complications of diabetic retinopathy such as neovascularization, vitreous hemorrhage, retinal edema and retinal detachment are frequent causes of visual loss in claims seen by the SSA. If you have diabetes and poorly controlled blood glucose levels, a decrease in your central visual acuity may be improved with better control of your diabetes; this is an effect separate from permanent eye damage from diabetes. If it appears that your visual loss is due to poor diabetic control, the SSA may wait until your diabetes is better treated before reaching a final decision on your claim. Similarly, if you are undergoing eye surgery, such as laser treatments for diabetic retinopathy, the SSA may hold your claim until the outcome of the surgery is known.

Satisfying the requirements of this listing qualifies as statutory blindness.

a. Listing Level Severity

To be severe enough to meet the listing, the remaining vision in your better eye after best correction must be 20/200 or worse.

b. Residual Functional Capacity

Poor acuity for distant vision can mean significant restrictions in your ability to function, even if your condition is not severe enough to satisfy the requirements of the listing.

1. Visual (distance) acuity of 20/50 or worse after best correction in the better eye is a significant impairment for which the SSA must provide an RFC rating. An acuity of 20/50 would prevent only performance of those jobs requiring very excellent vision, such as a pilot. Since there are many jobs not requiring excellent vision, an acuity of 20/50 or 20/60 is by itself of little consequence in disability determination. You could, however, have other impairments that add significance when combined with even a modestly decreased acuity. The most striking example is mental Listing 12.05[©] (Chapter 27)—an IQ of 60–70. That and any significant work-related impairment is enough to meet the listing. An acuity of 20/50 (or worse) is enough to require the SSA to give a physical RFC, and if the SSA gives an RFC it is by definition significant and work related.
2. A best-corrected distance acuity of 20/70 is the cut-off in many states for having a driver's license, though with such acuity you would be far from statutorily blind. This acuity is most important when your prior work has been driving some type of commercial vehicle. If your vocational factors don't permit you to do some other kind of work, then you could be found disabled.
3. While this listing does not involve central acuity for near vision, in unusual cases your near vision may enter into your RFC rating. If you have an uncorrectable problem with near vision and can perform only jobs requiring good near vision—such as reading papers, charts or blueprints—it is possible that you would be granted disability. If you have a problem seeing close-up, make sure you tell the SSA so specific testing of near vision can be done.
4. If you have uncontrolled advanced diabetic retinopathy, you are at risk for bleeding from your retina. The SSA should recognize your restrictions on lifting and frequent bending or kneeling. In the worst cases, you should not lift more than ten pounds—an RFC for no higher than sedentary work—in addition to whatever visual restrictions you suffer.
5. If you suffer from a detached retina or are at risk of one—for example, because of advanced diabetic retinopathy,

certain types of retinal degeneration or high myopia—the SSA should provide you with an RFC restricting you to no more than medium work with occasional bending or kneeling. Your RFC should also have you avoid work where there's a danger of your head being subjected to jarring motions, such as driving heavy equipment like trucks and tractors. Your RFC rating should include these restrictions even if you have not suffered an actual retinal detachment or if your detached retina (resulting from one of the listed disorders) has been surgically repaired. If your risk of a detachment is particularly severe, for example, you have a history of prior multiple detachments, your RFC for lifting should be even lower—possibly for sedentary work—maximum lifting of ten pounds.

2. Listing 102.02: Impairment of Visual Acuity (Children)

The introductory comments for Listing 2.02: Impairment of Visual Acuity (Adults), also applies here. In young children, retrolental fibroplasia and congenital eye problems—such as malformations and congenital cataracts—may be causes of blindness. Also, severe nystagmus can cause visual loss, since the constant jerking motion of the eyes prevents clear focusing on detail. Amblyopia can result from strabismus, but most cases involve only one eye and so cannot qualify under the listing. None of these disorders can be improved with glasses or contact lenses.

In children who are too young to identify letters on a standard Snellen chart, but old enough to cooperate in testing, there are charts with pictures that can be used instead.

a. Listing Level Severity

To meet the listing, the child's condition must satisfy [Ⓐ] or [Ⓑ].

- [Ⓐ] Remaining vision in the better eye after best correction is 20/200 or worse.
- [Ⓑ] The child is under three years of age and meets one of the following:
 1. The child is six months of age or older and lacks accommodative reflex. (Accommodative reflex is normally absent under six months of age.) Absence in a child of six months or older is indicative of blindness. If the child was born prematurely, the degree of prematurity must be added in. For example, if the child was born two months premature, he would have to be at least eight months old before the absence of an accommodative reflex could be used to meet the listing.
 2. Retrolental fibroplasia with scarring of the macula or neovascularization.

3. Bilateral congenital cataracts when associated with only a red reflex or with another type of eye abnormality. Severe congenital cataracts prevent a doctor from seeing through the opacity of the lens, and so the retina cannot be examined visually. If the doctor can't see in through the lens to the child's retina, it is a reasonable presumption that the child cannot see out through the lens either. If a child has cataracts and a doctor can obtain only a red reflex, then the child must have marked visual loss. This listing is also satisfied by the presence of cataracts and any other type of eye abnormality of any degree of severity.

Parts ①, ② and ③ take into account the fact that children under three years old cannot adequately cooperate in visual testing, and that a doctor must use other methods to determine whether the child suffers from serious visual loss.

3. Listing 2.03: Contraction of Peripheral Visual Fields in the Better Eye (Adults)

Because of the importance of peripheral visual field testing to many visual disability claims, this listing contains more detail than others. Use this detail to identify possible errors and oversights by the SSA, such as not testing your peripheral vision when it should be tested.

Keep in mind that this listing deals only with *peripheral* visual fields. Many treating ophthalmologists submit a tangent screen to the SSA; because this test measures only the center part of the visual fields, it is not sufficient to determine whether your peripheral visual fields are intact. Therefore, your claim should not be denied by the SSA under this listing with only the use of a tangent screen.



Although optometrists can provide the SSA with the results of peripheral visual field testing, the diagnosis of a visual disorder necessary to establish disability must come from a medical doctor or osteopath licensed to practice medicine.

a. Common Disorders Affecting Peripheral Vision

If you have diabetic retinopathy, by the time you have visual field losses severe enough to qualify under this listing you would probably already be granted benefits under Listing 2.02 for loss of visual acuity. If you have not been granted benefits under Listing 2.02 and have advanced diabetic retinopathy, the SSA should have your visual fields tested.

Glaucoma tends to eliminate the peripheral visual fields from the outside in, as if vision were being narrowed down into a tube, and may just about wipe out visual fields before central visual acuity is affected. So if you have glaucoma, it is not enough to have only your central visual

acuity measured—you must also have your peripheral visual fields tested. The SSA should not decide your claim until such testing has been done. An exception might be if you have glaucoma in only one eye as a result of trauma. Otherwise, glaucoma almost always affects both eyes and visual field testing can make the difference between allowance and denial.

Some strokes on one side of the brain can produce homonymous hemianopsia, but the SSA may not investigate it. You might be preoccupied with other aspects of your stroke—such as paralysis—and not report visual loss; or you may be depressed or otherwise have difficulty thinking clearly. If you have had a stroke and believe your vision has been affected, let your treating doctor and the SSA know so you can be properly evaluated. Because visual pathways exist in both sides of the brain, you cannot completely lose peripheral vision with a stroke that affects only one side of the brain. Multiple strokes affecting both sides of the brain, however, can cause serious losses in peripheral vision. Unless there is damage to the primary visual cortex of the brain, strokes usually do not affect central visual acuity—there is macular sparing.

Even if you do not meet a visual listing as a result of a stroke, peripheral visual field losses can produce important restrictions in your RFC. To make matters more complicated, a stroke patient may not be able to process visual information in certain parts of their visual fields—even though they can see objects, they do not recognize them.

Pituitary tumors press on the visual nerve fibers in the optic chiasm and can produce bitemporal hemianopsia. For this reason, peripheral vision should be tested and if you have such a tumor, the SSA should not decide your claim without testing. Pituitary tumors are more likely to affect peripheral vision than central visual acuity, unless they are very large.

Losses in peripheral vision cannot be corrected with lenses. The SSA should never deny your claim based on claiming that visual field losses can be improved with glasses or contact lenses.

b. How SSA Measures Peripheral Vision

Peripheral visual fields are measured with a device called a perimeter. The essence of perimetry is for you to look at a fixed point, and then without moving your eye, state when you can see test objects as they are moved in toward the center of your vision. The closer to your center of vision a test object must come before you can see it, the smaller your visual field. The visual field size is measured in circles drawn around the center point of visual fixation. Each circle represents an increase of field size by 10°; the largest circle

is about 90°. Each eye is tested separately and the results are plotted on charts for the right and left eye. The result shows the size and shape of your remaining visual field. Testing of your peripheral visual fields should not be done while you are wearing glasses (contacts are okay) because the frames of the glasses may interfere with your ability to see the test objects. If for some reason you were tested wearing glasses and denied benefits, note this fact to the SSA.

Most ophthalmologists and optometrists use automated perimeters to measure peripheral visual fields. You simply sit and look into a bowl-shaped instrument, fixating your gaze on a pre-determined point. The machine then flashes circles of light of varying sizes and brightness around the inside surface of the bowl and you indicate when you can see one by pressing a button. The test determines how much peripheral vision you have left. Many states use a less sophisticated version of automated perimetry as a part of visual testing for renewal of a driver's license, but these results are not accurate enough for disability determination and should never be used by the SSA as a basis for denying your claim.

The SSA prefers that peripheral vision be tested manually using a Goldmann perimeter. Very specific test conditions are required. But most ophthalmologists and optometrists use automated equipment because it saves them time. Fortunately, the SSA will now accept automated peripheral vision testing, if it conforms to SSA's testing requirements.

It is much easier to understand how visual fields are measured if you can see an example plotted out on a visual chart. (See Figure 1 below.) The point of visual fixation during testing is in the center, where all of the straight lines (meridians) intersect. The heavy black line marks the outer edge of the fields in the right and left eyes. The size and shape of the visual field in the right eye is normal, while that in the left eye is abnormally small.

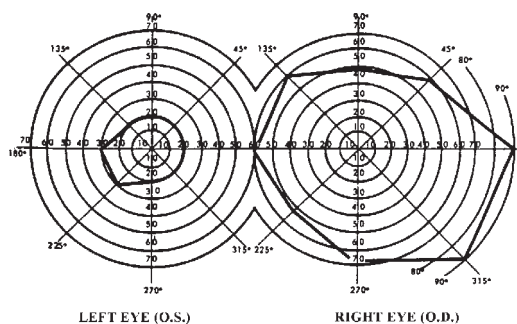


Figure 1

c. Listing Level Severity

To meet the listing, you must satisfy ①, ② or ③. Satisfying the requirements of part ① or ② of this listing qualifies as statutory (legal) blindness.

- ① Contraction of the peripheral visual field in the better eye to 10° or less from the point of fixation. The visual field in Figure 1 would not qualify because the better (right) eye has a normal field. Even if the right eye had a field as small as that in the left eye, this listing would not be satisfied because the field extends out past the 10° circle.
- ② Contraction of the peripheral visual field in the better eye so that the widest diameter is no more than 20°. The visual field must be as small as in part ①; it just doesn't have to be measured from the point of fixation.
- ③ Contraction of the peripheral visual field in the better eye such that visual field efficiency (VFE) is 20% or less. The person with visual fields as in Figure 1 could not qualify because the visual field in the better (right) eye is normal and would have a VFE of 100%.

d. Residual Functional Capacity

Medical judgment must be carefully applied in each person's case. Your RFC should state that you cannot work at unprotected heights or around hazardous machinery. Hazardous machinery includes motor vehicles, tractors, forklifts, saws, cranes or any other type of equipment that can be potentially dangerous to you or others if you don't have good peripheral vision. For example, if you were driving heavy equipment with poor peripheral vision you might not see other vehicles coming or you might hit someone else on a road or construction site. Also, you would have difficulty staying out of the way of dangerous equipment moving around you.

Similarly, the risk of falling from unprotected heights as a result of poor peripheral vision should keep the SSA from sending you to certain jobs. For example, you should not be a steel worker walking along the beams of a skyscraper under construction or even a roofer working on ordinary houses. Risk of injury is not the only factor to be considered regarding work with restricted peripheral fields—if you do assembly line work, you might be unable to keep up with parts moving along a conveyor belt.

4. Listing 2.04: Loss of Visual Efficiency (Adults)

Do not confuse visual efficiency with visual field efficiency, discussed in Listing 2.03C, above. Visual efficiency involves a calculation of overall visual loss in an eye by combining visual field efficiency and central visual efficiency. A two-step formula for calculating visual field efficiency is given under Listing 2.03.

Visual acuity efficiency is also easily determined by referring to tables that assign percentages to different central visual acuities, as follows:

Central Visual Acuity	Percent Visual Acuity Efficiency
20/16	100
20/20	100
20/25	95
20/32	90
20/40	85
20/50	75
20/64	65
20/80	60
20/100	50
20/125	40
20/160	30
20/200	20

This table assumes that you have either your natural lenses in both eyes, or artificial lenses in your eyes (intra-ocular lenses surgically placed). It is not relevant whether or not you have corrective lenses in the form of glasses or contact lenses, because the table refers to your best-corrected acuity by an eye doctor's special equipment and not how well you see with your own glasses or contacts. It is easy to see that if you have 20/20 visual acuity in an eye, then that eye has a 100% visual acuity efficiency. On the other hand, a 20/100 acuity has a visual acuity efficiency of only 50%. Your visual acuity efficiency percent will be even lower if you suffer from some types of aphakia, but this involves more complicated rules that are not provided in the above table.

Visual efficiency in each eye is obtained by applying the formula $\text{visual efficiency} = \text{visual field efficiency} \times \text{visual acuity efficiency}$.

EXAMPLE: Your visual field efficiency in the better eye is 40% as revealed by peripheral visual field testing with a Goldmann perimeter. Also, your best-corrected visual acuity in that eye is 20/100, which translates to a visual acuity efficiency of 50%. Your visual efficiency is 20%—the visual field efficiency (40%) times the visual acuity efficiency (50%). Note that one eye might be “better” in visual acuity, while the other eye might be “better” in the amount of peripheral visual field remaining. The listing applies to the eye that has the best visual efficiency.

a. Listing Level Severity

Visual efficiency of your better eye after best correction of 20% or less.

b. Residual Functional Capacity

See discussion of RFC under Listing 2.03. The presence of poor central visual acuity in addition to visual field loss would further restrict visual function and therefore produce even more limitations in possible jobs that the SSA could find for you to perform. Medical judgment must be applied on a case-by-case basis.

5. Listing 2.06: Total Ophthalmoplegia (Adults)

Few people qualify for disability under this listing because total ophthalmoplegia is rare.

a. Listing Level Severity

For your condition to be severe enough to meet the Listing, you must have ophthalmoplegia in both eyes.

b. Residual Functional Capacity

See discussion of residual functional capacity under Listing 2.03. Because of inability to move the eyes, total ophthalmoplegia would result in the same kinds of restrictions as severe visual field loss, although field loss is not actually involved.

Part II. Balance and Hearing Disorders

Definitions

The following definitions are for words used in this section. If you need additional definitions, consult a good medical dictionary, available in most bookstores or libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Air conduction audiometry. Test of ability to hear sound transmitted through the air.

Audiologist. A person specially trained to perform audiometry. Audiologists are not medical doctors.

Audiometry. Hearing test, usually consisting of both pure tone audiometry and speech audiometry.

Auditory evoked response (AER). The brain's electrical response to sound, which can be detected on the scalp.

Auditory tube. Connects the middle ear to the nasopharynx. Also called *eustachian tube*.

Bone conduction audiometry. Test of ability to hear sound transmitted through bones in the middle ear.

Benign positional vertigo (BPV). Vertigo associated with certain positions of the head. It is called benign, because it will improve over a period of weeks or several months and is not usually a cause for great concern.

Brainstem auditory evoked response (BAER). See *auditory evoked response*.

Caloric testing. Test of the vestibular apparatus by putting hot or cold water in the outer ear.

Central hearing loss. Caused by damage to brain areas needed to process information from the ears.

Cholesteatoma. Noncancerous tumor, most common in the middle ear.

Cochlea. Organ of hearing. Also called the inner ear.

Conductive hearing loss. Caused by disease or trauma to the small bones in the middle ear.

Deaf mutism. Profound deafness associated with inability to understand or use spoken language.

Decibel (dB). Unit of sound intensity.

Electronystagmometry (ENG). Measuring of eye movements to detect nystagmus.

Eustachian tube. See *auditory tube*.

External ear canal. Outer part of the ear canal, through which the atmospheric pressure of sound enters the ear. Also called *external auditory canal*.

Hearing threshold sensitivity. The decibel level at which a sound can just be heard.

Hertz (Hz). Sound frequency in cycles per second.

Labyrinthine-vestibular function. Hearing and balance functioning of the labyrinth—the inner ear and the vestibular apparatus.

Middle ear. Space between the eardrum and inner ear. Contains small bones that transmit the force of sound to the inner ear.

Nasopharynx. Area above the throat into which the airways of the nose enter.

Nystagmus. Abnormal, rhythmic, oscillating movements of one or both eyes. The oscillations may be in a vertical direction or, more frequently, horizontal. Induction of temporary nystagmus with caloric testing (test of the vestibular apparatus by putting hot or cold water in the outer ear) is a method of testing vestibular function.

Otolaryngologist. Ear, nose and throat (ENT) specialist.

Otoscopy. Visual examination of the outer ear canal and eardrum using a lighted instrument (otoscope).

Pure tone audiometry. Test of the ability to hear pure sound frequencies transmitted through the air or bone.

Pure tone average (PTA). The average air conduction hearing loss determined with pure tone audiometry. Also known as the average hearing threshold sensitivity for air conduction.

Sensorineural hearing loss (SNL). That caused by damage to the inner ear or acoustic (auditory) nerve to the inner ear.

Speech audiometry. Test of ability to identify spoken words.

Speech discrimination. Percentage of spoken test words that can be correctly identified during speech audiometry, measured at about 30–40 dB above the speech reception threshold—the lowest decibel intensity at which special test words can be heard.

Speech reception threshold (SRT). Lowest decibel intensity at which special test words can be heard. Does not measure whether a word can be heard well enough to be identified. Normally, the SRT is about 30 dB.

Tinnitus. Abnormal sound heard in the ears when there is no actual sound. Tinnitus is usually a ringing, but it may be a buzzing or other type of sound.

Tympanic membrane (TM). Eardrum.

Vertigo. Condition of hallucination of motion, either where objects seem to move in relation to you (objective vertigo) or you seem to be moving in relation to other objects (subjective vertigo). Vertigo of a spinning sensation is called rotary vertigo. Most people describe vertigo as dizziness, but they also use dizziness when they mean light-headedness, unsteadiness, confusion or loss of consciousness. You must be able to clearly describe your symptoms to the SSA as vertigo or something else; words like dizziness or light-headedness are not specific enough. Vertigo decreases the ability to maintain balance.

Vestibular apparatus. Part of the inner ear that helps maintain balance by providing the brain with constant information about the position of the head. The vestibular apparatus consists of three semicircular, fluid-filled canals (tubes) at right angles to each other, as well as several other fluid-filled spaces.

A. General Information

Hearing loss is a frequent claim of disability applicants. Many people have hearing loss because of exposure to loud sounds over a period of years. While most people know to wear hearing protection when they shoot firearms, few realize that they should protect their hearing when using lawnmowers, weed-trimmers, leaf-blowers or similar loud equipment. Damage to hearing because of loud sounds is far more common than conductive hearing loss. Some claimants tell the SSA that they can't hear anything even when tested, although they seem to have no abnormalities that would cause a hearing loss and have no prior history of profound deafness. In these cases, the SSA might use auditory evoked response testing to identify abnormalities in the brain's hearing pathways that could explain the loss. If the SSA cannot find a cause for the alleged deafness, the SSA won't grant disability benefits.

If you suffer a damaged vestibular apparatus, you may have difficulty with balance from vertigo. You may also experience nausea and vomiting. Most vestibular disturbances result from conditions such as benign positional vertigo, viral infections, drug toxicity or allergies, and rarely last more than a few months. A condition known as Meniere's disease, however, is much more serious. It may be associated with attacks of severe vertigo, and associated nausea, vomiting and loss of balance. And, Meniere's disease causes a progressive hearing loss. Vestibular testing is done by otolaryngologists. Defects in balance due to brain disorders often occur—such as after strokes—but would be evaluated under the neurological listings in Chapter 26.

Before applying a listing, the SSA requires physical examination of your ears, nose and throat by an otolaryngologist. This is to identify possible causes of your disorder to help determine severity and likelihood of improvement. For example, otoscopy might reveal an ear infection, ruptured tympanic membrane (ear drum) or cholesteatoma. Allergies can cause the auditory tube to block off and fluid to build up in the middle ear because it can't drain into the nasopharynx. All of these disorders can cause hearing loss or vertigo, but expected treatment outcomes vary greatly.

1. Listing 2.07: Disturbance of Labyrinthine-Vestibular Function (Adults)

The most frequent cause of serious labyrinthine-vestibular dysfunction is Meniere's disease. Using a caloric test, a doctor puts hot or cold water into the external ear canal; the water transmits temperature changes to the vestibular apparatus on that side of the head. These temperature changes

set up currents inside the fluid in the vestibular apparatus. Responses to the currents can provide information about whether the vestibular apparatus is normal. Using the caloric test, a doctor can also record the eye movements of nystagmus (electronystagmometry, ENG) and evaluate symptoms of vertigo, nausea and vomiting.

In order to document the severity of Meniere's disease, the SSA requires that the "... severity of impairment be determined after prolonged observation and serial re-examinations." Therefore, your doctor needs to provide detailed information about your condition over as long a period as possible. Your attacks of balance disturbance should be described in regard to intensity, frequency of occurrence and duration. Hearing loss must be documented as worsening, and this requires multiple audiometric tests. Your treating otolaryngologist should have this information. If you have had surgery for Meniere's disease, it is possible that the SSA will want to wait a few months to evaluate the outcome before making a final decision.

a. Listing Level Severity

The listing requires that you suffer frequent attacks of balance disturbance resulting from vertigo, ringing or tinnitus and worsening loss of hearing. Also, you must satisfy ① and ②.

- ① Vestibular disturbance shown through a caloric or other tests.
- ② Hearing loss established by audiometry.

b. Residual Functional Capacity

If you suffer from significant vertigo, you should not work at jobs requiring good balance, including work at unprotected heights or around hazardous machinery. Hazardous machinery includes motor vehicles, tractors, forklifts, saws, cranes or any other type of equipment that can be potentially dangerous to you or others if you have a sudden attack. Also, during an attack of vertigo, you would have difficulty staying out of the way of dangerous equipment moving around you. Similarly, the risk of falling from unprotected heights as a result of vertigo should keep the SSA from sending you to certain jobs. For example, you should not be a steel worker walking along the beams of a skyscraper under construction or even a roofer working on ordinary houses, if you have significant vertigo. Medical judgment must be carefully applied on a case-by-case basis.

2. Listing 2.08: Hearing Loss (Adults)

The SSA uses audiometry to determine the severity of hearing loss. Profound deafness of any cause, uncorrectable by a hearing aid, is needed to qualify under this listing. The

SSA typically evaluates a hearing loss using audiometry as follows:

1. The SSA considers your audiometry results without hearing aids in place. If test results do not qualify you under the listing or on a medical-vocational basis using an RFC, no further hearing loss testing will be done. If test results qualify you under the listing or fit an allowance on a medical-vocational basis, you will still not be awarded disability payments. Instead, the SSA will go to Step 2.
2. The SSA tests your hearing with your own hearing aids, if you have them. If you are still not eligible under a listing or on a medical-vocational basis, no further hearing-loss testing will be done. If you qualify under the listing or on a medical-vocational basis, the SSA will allow your claim. If you do not own hearing aids, or if they are functioning poorly, the SSA will go to Step 3.
3. The SSA tests your hearing with high quality hearing aids. This will require several trips and might take several months.

a. Listing Level Severity

To meet the listing, you must satisfy Ⓐ or Ⓑ—despite the use of hearing aids.

- Ⓐ Average hearing threshold sensitivity for air conduction of 90 decibels (dB) or greater in the better ear, and a corresponding loss in bone conduction. This listing involves pure tone audiometry and requires that average hearing loss—pure tone average—be calculated by using the sound frequencies of 500 hertz (Hz), 1,000 Hz and 2,000 Hz.

EXAMPLE: You can't hear the 500 Hz frequency until it is at least 100 dB—in other words, you have a hearing threshold sensitivity of 100 dB for the 500 Hz frequency sound. You also have a 75 dB hearing threshold sensitivity for the 1,000 Hz frequency and a sensitivity of 95 dB for the 2,000 Hz sound. The pure tone average is $100 + 75 + 95 = 270$ dB divided by $3 = 90$ dB. This is a profound hearing loss and would meet the listing if it could not be improved with a hearing aid. The corresponding average loss in hearing by bone conduction is not specified in the listing, but it would have to be about 60–65 dB.

- Ⓑ Speech discrimination score of 40% or less in the better ear. This listing recognizes the fact that the ability to hear pure tones of sound (part Ⓐ) is not the same as being able to understand spoken words because words are a mixture of tones. If you cannot identify speech sounds more than 40% of the time when words are read

to you from a standard test list, then you are going to have a great difficulty talking to other people and your hearing loss will meet the listing. As a general rule, speech discrimination should not suffer much until the pure tone average in the better ear is 40 dB or worse.

If you have a lifelong documented history of deaf mutism, the SSA will not test for improvement with hearing aids. Even if your air conduction thresholds could be improved with high amplification through a hearing aid, you would still continue to qualify based on lack of speech discrimination. (If you've never used speech, then you are not going to understand it no matter how loud it is, as you have passed the critical childhood brain development period necessary for understanding speech.)

b. Residual Functional Capacity

The SSA does not have set rules regarding RFCs for hearing impairments that do not meet the listing. Both your pure tone hearing loss and your speech discrimination can affect the severity of your hearing impairment, and medical judgment is applied case by case. The charts below give you an idea of when the SSA thinks hearing aids are needed.

Pure Tone Average and Functional Loss

Hearing level (dB)	Degree of Loss	Speech Understanding	Hearing Aid
0–25	Normal	Normal	Not needed
26–40	Mild	Difficulty with soft speech	Not usually needed
41–55	Moderate	Frequent difficulty with normal conversational (45–50 dB) speech at three feet	Frequently helpful; must also consider speech discrimination
56–70	Moderate – Marked	Frequent difficulty with loud (65 dB) speech at three feet	Frequently needed; must also consider speech discrimination
71–89	Marked	Understands only shouted or amplified speech	May be helpful; must also consider speech discrimination
90 or over	Extreme	No understanding of even amplified speech	May improve lipreading

Speech Discrimination		
Percent Discrimination	Quality of Discrimination	Functional Result
90–100%	Excellent	Normal discrimination
75–89%	Good	Slight difficulty sometimes, such as on telephone
60–74%	Fair	Moderate difficulty most of the time
41–59%	Poor	Difficulty in following conversation
40 or less	Very poor	Severe difficulty in conversation most of the time

If you have good speech discrimination (75% or higher) and an average pure tone loss of no worse than about 40 dB in the better ear, then you do not have much restriction and probably would not qualify for an RFC. Also, total deafness in one ear produces little functional restriction if hearing in the other ear is normal. More severe hearing losses should lead to RFC restrictions of your ability to work at jobs requiring good hearing, including good speech discrimination. In applying such an RFC to a medical-vocational determination of disability, the SSA would not send you to work as an air traffic controller, police dispatcher, disc jockey or telephone sales person. The SSA can cite many jobs that don't require good hearing,

An important consideration is how much difficulty you have in understanding speech against a lot of background noise or in a crowd. When the SSA tests discrimination, it does so in a quiet room. Most people, however, don't work in the quiet and it is well known that the presence of other sounds—especially other people talking—can greatly decrease speech discrimination. If you think you have this kind of problem, make sure that the SSA knows about it.

3. Listing 102.08: Hearing Loss (Children)

Children do not have to be tested for improvement with a hearing aid, if they cannot wear such a device effectively. While the SSA has no official age at which a child is supposed to be able to use a hearing aid without taking it off or breaking it, the exemption from being tested without a hearing aid would be most applicable to children under five years of age. But the SSA must apply medical judgment case by case.

Infants cannot cooperate in any of the types of testing mentioned by the listing, but auditory evoked responses can nevertheless be used to determine that sounds are being heard by the infant's brain. Audiologists using the proper equipment can test for evoked responses at each specific sound frequency required by the listing.

a. Listing Level Severity

To meet the listing, the child's condition must satisfy ① or ②. Where feasible, testing with hearing aids should be done.

- ① For children under five years old at the time of disability determination, inability to hear air conduction thresholds at an average of 40 dB or greater in the better ear. This is very similar to adult Listing 2.08①. The SSA averages decibel intensities of sound required to hear frequencies of 500, 1,000, 2,000 and 3,000 Hz. No bone conduction testing is required. Only a 40 dB or higher average air conduction threshold is required to satisfy the listing. This is an easier requirement than for adults because younger children with even modest hearing losses often have problems with speech and language development.
- ② Children at least five years old at the time of the disability determination must meet 1, 2 or 3:
 1. Inability to hear air conduction thresholds at an average of 70 dB or greater in the better ear. Air conduction is tested at frequencies of 500, 1,000, 2,000 and 3,000 Hz. No bone conduction testing is required.
 2. Speech discrimination scores of 40% or less in the better ear. This is the same as adult Listing 2.08②.
 3. Inability to hear air conduction thresholds at an average of 40 dB or greater in the better ear, and a speech and language disorder which significantly affects the clarity and content of the speech and is attributable to the hearing impairment. This is the same as part ①, with the added requirement that a significant speech and language disorder be documented. The SSA obtains speech and language evaluations by sending the child to a speech pathologist or speech therapist.

Part III. Loss of Speech

Definitions

The following definitions are for words used in this section. If you need additional definitions, consult a good medical dictionary, available in most bookstores or libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Cerebral palsy. Any nervous system disorder dating from the time of birth that is not progressive.

Cicatricial laryngeal stenosis. Narrowing of the larynx because of scarring.

Cleft palate. Congenital fissure in the palate.

Dysarthria. Inability to speak clearly.

Electrolarynx. An electronic device held to the side of the throat to help in producing artificial speech.

Esophageal speech. Speech created by swallowing air then controlling the way it is brought back up. Not everyone can learn esophageal speech.

Glossectomy. Surgical removal of the tongue.

Hypernasality. Excessive movement of air out of the nose when speaking; degrades the intelligibility of speech.

Laryngectomy. Surgical removal of the larynx (voice-box).

Palate. The horizontal partition that separates the oral and nasal cavities. The roof of the mouth.

Speech. The production of sounds (phonemes) in a smooth and rhythmic fashion for the purposes of oral communication. Speech includes articulation (uttering, enunciating and pronouncing), voice (pitch, volume and quality) and fluency (the flow, or rate and rhythm, of speech). Understandable speech results from precise neuromuscular functioning (coordination of function between the nervous system and the muscles controlled by it) of the speech mechanism (lips, tongue, hard palate, vocal folds and respiratory mechanism), and intact structure and functioning of the speech centers in the brain.

Vocal cords. Two (right and left) strands of tough tissue in the larynx that vibrate to produce sounds.

A. General Information

Many impairments can cause limitations in speech, including brain lesions (strokes, trauma or tumors), cerebral palsy producing dysarthria or a cleft palate causing a hypernasality. Glossectomy, laryngectomy or cicatricial laryngeal stenosis can interfere with your ability to produce useful speech. Cicatricial laryngeal stenosis may be caused by prior infection or traumatic damage. These are organic causes of speech loss, in contrast to loss of speech related to mental disorders. Loss of speech related to mental disorders are evaluated in Chapter 27. Loss of speech related to strokes or other nervous system disorders are evaluated in Chapter 26. Only speech problems related to physical damage to the structures of speech are considered here.

1. Listing 2.09: Loss of Speech (Adults)

Most of the organic loss of speech seen by the SSA involves laryngectomies and glossectomies done because of cancer resulting from cigarette smoking or chewing tobacco.

You cannot qualify under this listing from loss of speech unless you can show an inability to produce useful speech by any means, including esophageal speech or electro-larynx. "Useful" speech means it must be loud enough to be heard, it must be spoken clearly enough to be understood and you must be able to sustain a reasonable amount of speech for effective communication.

a. Listing Level Severity

Organic loss of speech due to any cause with inability to produce by any means speech that can be heard, understood or sustained.

b. Residual Functional Capacity

The severity of the speech loss must be evaluated on an individual basis using medical judgment. If you are not granted benefits under this listing but have significant difficulties speaking, the RFC should state that you cannot do work requiring good speaking ability. In applying such an RFC to a medical-vocational determination of disability, the SSA would not send you to work as an air traffic controller, police dispatcher, disc jockey or telephone salesperson, but the SSA can cite many jobs that don't require more than minimal verbal communication. ■

Chapter 18

Breathing Disorders

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Apnea. Cessation of breathing. See also *obstructive sleep apnea* and *central sleep apnea*.

Arterial blood gases (ABGS). The measurement of oxygen gas pressure, carbon dioxide gas pressure, acidity and bicarbonate concentration in the blood. A sample of arterial blood is usually obtained in a syringe by needle puncture of the radial artery in the wrist. See *PaO₂*, *PaCO₂*.

Asthma. Type of chronic obstructive pulmonary disease characterized by episodes of narrowing of bronchial airways. Such narrowing results from excessive secretions, inflammation and constriction of bronchial muscles. Also called *reactive airways disease* and *asthmatic bronchitis*.

Bronchi. Larger airways branching from the trachea to the lungs.

Bronchiectasis. Condition involving specific areas of chronic damage and infection in the bronchial airways.

Bronchitis. Inflammation of bronchial airways; may be associated with infection or other sources of irritation such as allergy, smoke or chemical fumes. See also *chronic bronchitis*.

Bronchodilator. Drug that relaxes muscles in the bronchial airways so that they can enlarge (dilate).

Bronchopulmonary dysplasia (BPD). Chronic obstructive lung disease that starts in a newborn because of lung injury. Such injury might result from premature lungs (respiratory distress syndrome), pneumonia, episodes of cessation of breathing (apnea of prematurity) or other disorders that damage the lungs.

Carbon monoxide diffusing capacity (DLCO). Harmless breathing test using carbon monoxide gas as a measure of gas exchange. Mostly used with patients with fibrotic lung disease.

Cardiac catheterization. Insertion of hollow tubes (catheters) into the heart's chambers or arteries supplying the heart, for treatment purposes, pressure readings or x-rays. Pressure readings may also be made in the pulmonary arteries and aorta (largest artery in the body, arising from the left ventricle of the heart).

Central sleep apnea. Cessation of breathing caused by a disorder of the brain.

Chronic bronchitis. Type of obstructive pulmonary disease caused by persistent inflammation, secretions and resultant narrowing of the bronchial airways. The most common cause of chronic bronchitis is cigarette smoking.

Chronic obstructive pulmonary disease (COPD). Type of lung disease characterized by resistance to airflow in and out of the lungs. Also known as chronic obstructive lung disease (COLD).

Chronic pulmonary insufficiency. Any type of persistent breathing disorder.

Computerized axial tomography scan (CAT scan, CT scan). X-rays taken under computer guidance, consisting of many picture slices of high resolution; show much greater detail than plain x-rays.

Cor pulmonale. Damage to the right side of the heart caused by lung disease.

Corticosteroids. Drugs that have the same action as the natural steroid hormone cortisol. Corticosteroids help combat many diseases, but their side effects can be serious if taken for a long time. Chronic use of steroids also indicates the severity of the disease being treated.

Cyanosis. Bluish discoloration of the skin and mucous membranes that indicates inadequate oxygenation of tissues. It is most easily observed in the fingertips, toes, lips, earlobes and nose.

Cystic fibrosis. Genetic disorder associated with lung disease and deficiency of pancreatic digestive enzymes.

Diuretic. Drug that increases the loss of water from the body through increasing the formation of urine by the kidneys.

Dyspnea. Shortness of breath or the sensation of inability to get enough air.

Echocardiogram. Image of the heart using high-frequency sound.

Electrocardiogram (EKG, ECG). Recording of the heart's electrical activity on the surface of the chest.

Emphysema. A common type of chronic obstructive pulmonary disease, most frequently caused by cigarette smoking. In emphysema, hyperinflation and an increased chest diameter cause "obstruction" or resistance to the normal flow of air in and out of the lungs.

Expiration. Breathing out, or exhaling.

Fibrotic lung disease. Type of restrictive lung disease that involves inability of the lung to carry out gas exchange between carbon dioxide and oxygen—such as pneumoconiosis.

Flaring. Widening of the nostrils in infants. A sign of difficulty breathing.

Flow-volume loop. Type of spirometry in which the result shows the rate of airflow in relation to volume of air.

Forced expiratory volume (FEV). Maximum volume of air that can be expired through the mouth with maximum effort, after taking as deep a breath as possible. The FEV should not be confused with the FEV1. The FEV is the same measurement as the FVC.

Forced expiratory volume in one second (FEV1). The volume of air in the first second of the FEV. The FEV1 is the most important measurement for the severity of chronic obstructive pulmonary diseases such as emphysema, chronic bronchitis, asthma and bronchopulmonary dysplasia. The FEV1 is decreased in these conditions.

Definitions (continued)

Forced vital capacity (FVC). Same as FEV, but preferred usage is FVC.

Gas exchange. Ability of carbon dioxide waste gas to pass from the blood into the air, and for oxygen to pass from the air into the blood. Gas exchange takes place across the delicate membranes that make up the alveoli (tiny air sacs of the lungs), where the air and blood are very close to each other.

Hemoptysis. Coughing up blood.

Hepatomegaly. Enlarged liver.

Hyaline membrane disease. See *respiratory distress syndrome*.

Hyperinflation. Abnormal increase in the size of the lungs; a sign of obstructive lung disease, such as emphysema and bronchopulmonary dysplasia.

Hyperventilation. Abnormally increased rate and depth of breathing.

Hypoventilation. Decreased breathing with inability to move enough air in and out the lungs. Associated with decreased oxygen and increased carbon dioxide in the blood.

Hypoxemia. Decreased oxygenation of arterial blood.

Inspiration. Breathing in, inhaling.

Liter (L). Unit of air volume used in measuring lung functions. One liter is 1,000 milliliters (ml).

Lobectomy. Surgical removal of a lobe of a lung.

Lungs. Inflatable gas exchange membranes inside the chest cavity. There are right and left lungs, and each lung has several lobes.

Magnetic resonance imaging (MRI). Method of producing pictures of internal body structures using magnetic fields and radiofrequency fields. MRI does not use x-rays or other radiation.

Mechanical ventilation. Breathing assistance from a machine.

Mycobacteria. Group of bacteria, including the species causing tuberculosis (TB). Atypical mycobacteria may also cause infection.

Mycotic infections. Infections caused by fungi.

Nebulization. Making a liquid drug into a fine mist, so that it can be inhaled directly into the lungs.

Neck vein distention. Enlargement of the neck veins in a body position in which they should be flat; a sign of right heart failure.

Obstructive breathing disorders. See *chronic obstructive pulmonary disease*.

Obstructive sleep apnea. Decreased ability to move air in and out of the lungs during sleep, associated with episodes of cessation of breathing. Most common type of sleep apnea. Obesity is the major cause.

Oximetry. See *pulse oximetry*.

Oxygen saturation. See *pulse oximetry* and SaO_2 .

Oxygenation. Supply of oxygen to tissues.

PaCO_2 . Carbon dioxide pressure in arterial blood, expressed as millimeters of mercury (mm Hg). Normal value (at sea level) 35–45 mm Hg.

PaO_2 . Oxygen pressure in arterial blood, expressed as millimeters of mercury (mm Hg). Normal value (at sea level) 80–100 mm Hg.

Peak flow meter. Small, handheld device, used mainly by asthmatics to show the maximum rate of possible airflow by breathing forcefully through it.

Percentile. Method of comparing something (like height or weight) to normal expected values, in order to decide the chance (probability) that it is normal or abnormal. For example, a person with a weight in the 60th percentile is heavier than 60% of other people and lighter than 40% of other people.

Peribronchial disease. Disease around the bronchial airways.

Peripheral edema. Fluid retention in the feet or legs.

Pilocarpine iontophoresis. See *sweat test*.

Pneumoconiosis. Lung diseases caused by excessive breathing of small, dust-like particles such as asbestos, rock dust, coal dust or metal dusts (beryllium, barium, antimony, cobalt, tin, iron oxides, etc.). Pneumoconiosis can be associated with both obstructive and restrictive lung disease.

Pneumonectomy. Complete removal of a right or left lung.

Prolonged expiration. Abnormally long time to breathe air out of the lungs, as observed on physical examination.

Pulmonary. Related to breathing or the organs associated with breathing.

Pulmonary arteries. Arteries arising from the right ventricle of the heart, carrying blood to the lungs for oxygenation.

Pulmonary function study (PFS). Any kind of breathing test. Sometimes called *pulmonary function testing*.

Pulmonary hypertension. Type of pulmonary vascular disease resulting in elevated blood pressure inside the arteries of the lungs. Also known as *pulmonary vascular hypertension*.

Pulse oximetry. Method of measuring oxygen saturation in the blood without having to take an arterial blood sample or insert anything into a patient's artery. Done by attaching a small sensor to a finger or ear lobe.

Rales. Discontinuous abnormal breath sounds in the bronchial airways of the lungs that can be heard with a stethoscope.

Respiratory distress syndrome (RDS). Collapse of lung tissue in premature newborn infants. Lung tissue cannot be kept open because they lack sufficient quantities of a chemical called surfactant, needed to decrease surface tension on the lungs. Also known as *hyaline membrane disease*.

Restrictive breathing disorders. Any breathing disorder associated with decreased functional lung volume (e.g., obesity, thoracoplasty, weakness of respiratory muscles or lobectomy) or associated with disease of the lungs themselves that results in decreased gas exchange (such as pulmonary fibrosis).

Retractions. Strained contractions of the muscles of the chest wall or upper abdomen in infants who are having severe difficulty breathing.

Rhonchi. Continuous abnormal breath sounds in the bronchial airways of the lungs that can be heard with a stethoscope.

Definitions (continued)

Right-sided gallop. Abnormal heart sound, heard with a stethoscope, suggesting that damage has been done to the right side of the heart by the stresses put on it.

Right ventricle (RV). Right heart chamber that pumps blood through the lungs.

Right ventricular hypertrophy (RVH). An abnormality characterized by enlargement of the right ventricle. May be caused by lung disease, as in cor pulmonale. Can be seen on chest x-ray, echocardiograms, CT scans, MRI scans or detected by EKG.

Right ventricular outflow tract. Enlargement of the pulmonary arteries as they branch from the right ventricle.

SaO₂. Oxygen saturation of arterial blood, as measured by oximetry. Normal value (at sea level) 95–99%. SaO₂ is less accurate than arterial oxygen pressure (PaO₂) in evaluating blood oxygenation; it is more useful in noninvasive monitoring to detect changes in oxygenation.

Shortness of breath (SOB). See *dyspnea*.

Sleep apnea. Periods of breathing cessation during sleep.

Spirogram. Graphs showing the results of spirometry. Also called *spirometric tracings* or *spirometric curves*.

Spirometry. Breathing test which measures the ability to ventilate the lungs—the speed (rate of airflow), amount of air (volume) and pattern of air movement in and out of the lungs. Spirometry is valid only with maximum effort by the patient.

Sputum. Material coughed up from the lungs; may indicate infection or other disorders.

Sweat test. Test for chloride (and sometimes sodium) in the sweat. In patients with cystic fibrosis, chloride and sodium are decreased in sweat. Also known as *pilocarpine iontophoresis*.

Tachypnea. Increased rate of breathing.

Thoracoplasty. Surgical removal of part of the chest wall, including the ribs.

Time-volume spirograms. Type of spirometry which shows how much can be breathed out over time, after taking as deep a breath as possible. Requires maximum effort by the patient. Generally required by the SSA to satisfy a listing or serve as the basis for an RFC.

Trachea. The main airway connecting the mouth and nose to the lungs.

Tracheostomy. Surgically placed opening through the neck into the trachea. May be temporary or permanent, and is used to connect a respirator for mechanical ventilation for patients who need assistance in breathing. Patients who have had a laryngectomy (surgical removal of the voice box) also have a tracheostomy.

Ventilation. Movement of air in and out of the lungs.

Wheezing. Abnormal, high-pitched sound created when air flows through narrowed bronchi.

A. General Information

To establish that you have a disability based on a breathing disorder, you will have to provide the SSA with evidence including shortness of breath, laboratory test results such as pulmonary function studies and physical symptoms such as wheezing, chest pain and coughing up sputum or blood. If you have extremely advanced pulmonary disease, you may burn extra calories in breathing, and your symptoms may include a poor appetite, resulting in weight loss and malnutrition.

Although shortness of breath is the major symptom of breathing disorders, shortness of breath in and of itself does not indicate the severity of a breathing disorder. One reason is that factors unrelated to a breathing disorder, such as poor physical conditioning and other medical problems can affect whether you feel short of breath.

To test for a breathing disorder, your doctor may have administered a spirometry, arterial blood gas (ABGS) or carbon monoxide diffusing capacity (DLCO) test. The SSA will reject the results of any such test if the test was administered while you had an acute illness such as pneumonia, because the test results won't show your usual condition. Furthermore, regardless of the results of a properly administered breathing test, you must also provide the SSA with evidence from a physical examination and chest x-ray that you have significant lung disease. Without such evidence, the SSA is not likely to accept test results suggesting a breathing disorder.

Most breathing disorders are evaluated by spirometry, and the SSA will probably send you to a consultative examination for spirometry—even if your treating doctor has provided test results. Further testing may delay your claim for weeks or even months. There are several reasons the SSA often does its own testing:

- Many doctors and hospitals use spirometry done by flow-volume loop and the SSA requires time-volume spirograms.
- Many doctors and hospitals don't have the actual spirograms from testing, and the SSA cannot grant benefits without reviewing the actual tracings to make sure they are valid.
- Many doctors don't perform spirometry by the exacting requirements of the SSA.



Some claimants do not give their maximum effort during spirometry, and the test results are rejected by the SSA as invalid. To avoid the time delay of having to return for repeat testing, put forth your best effort. If your test spirogram shows poor effort on two tests, the SSA will be unable to assess the severity of your breathing disorder and your claim may be denied. Also, repeat testing is time consuming.

1. Obstructive and Restrictive Breathing Disorders

All breathing disorders can be classified as chronic obstructive pulmonary disease (COPD), a restrictive pulmonary disorder or a combination of both. All of the listings deal with these disorders or with complications related to them.

The three most common COPDs seen by the SSA are emphysema, chronic bronchitis and asthma. In adults, cigarette smoking, with both emphysema and chronic bronchitis usually occurring together, causes most COPD. Asthma is also markedly worsened by smoking. In children, most breathing disorders involve COPD associated with asthma, cystic fibrosis and bronchopulmonary dysplasia. The breathing test most often done on claimants with COPD is spirometry with measurement of the FEV1.

Restrictive breathing disorders are those in which there is a decrease in the amount of usable lung volume. Restrictive disorders may be caused by a disease of lung tissue itself, such as fibrotic lung disease. It is possible, however, to suffer from a restrictive disorder even when remaining lung tissue is normal—for example, because of pneumonectomy or lobectomy, thoracoplasty, spinal deformities, gross obesity or paralysis of breathing muscles as a result of a stroke or other neurological disorder. Most disability applicants with restrictive breathing disorders undergo spirometry with measurement of the forced vital capacity (FVC). If the restrictive disorder involves lung tissue, the SSA may require a test of gas exchange.

2. Ventilation and Gas Exchange

Breathing impairments may involve problems with ventilation of the lungs, in which there is difficulty moving air in and out of your lungs. They can also involve gas exchange disorders, in which damaged lung tissue blocks oxygen in the air from passing into the bloodstream, even when air can reach the lungs.

Some breathing disorders are purely ventilatory, such as with spinal deformities or obesity—you have healthy lung tissue, but difficulty moving air in and out of your lungs. Other breathing disorders are strictly gas exchange disorders—ventilation of the lungs is normal, but the lungs themselves are damaged. Fibrosis of the lungs is an example of a gas exchange disorder in which ventilation can be normal. Still other disorders, such as emphysema, cystic fibrosis and bronchiectasis, can involve lung damage as well as decreased ability to ventilate the lung.

While ventilation is tested by spirometry measuring the FEV1 and FVC, gas exchange is tested via DLCO and ABGS.

The SSA may have these tests administered to evaluate your breathing disorder, but they are less frequently needed than spirometry. Measurement of oxygen saturation by oximetry cannot be substituted for ABGS in the evaluation of severity, except in children less than 12 years of age.

3. Pulmonary Heart Disease

Pulmonary heart disease, or cor pulmonale, is heart disease resulting from lung disease. For example, recurrent blood clots to the lungs or inflammation of the pulmonary arteries can cause pulmonary hypertension. The high blood pressure can cause heart failure because of the heart's difficulty in pushing blood through the lungs. Listing 3.09 applies to pulmonary heart disease in adults. Pulmonary heart disease in children is considered under the child heart disease listings in Chapter 19.

One way to diagnose pulmonary heart disease involves directly measuring pressures inside the arteries of the lung by cardiac catheterization. This is an invasive test, and the SSA will not require an applicant to undergo such testing. If your treating doctor has done such testing, however, be sure the SSA gets the results.

4. Exercise Testing

In unusual circumstances, the SSA may ask you to undergo an exercise test with an ABGS to find out how much exercise you can tolerate without a dangerous drop in your arterial oxygen. If you are asked to undergo such a test, you will walk on a treadmill or ride a stationary bicycle while your vital signs (heart rate, breathing rate and blood pressure), EKG and overall condition are monitored.

An exercise test can be dangerous to someone with a breathing impairment. Before you undergo exercise testing, a doctor should physically examine you to make sure it is safe. Only a pulmonary specialist or cardiologist with pulmonary expertise should perform pulmonary exercise testing. The SSA should not order the test if it can grant your claim in some other way. Most patients with advanced lung disease sufficiently severe to qualify for disability benefits can be evaluated without exercise testing. Under no circumstances should a disability examiner, case manager, hearing officer or someone other than a doctor working for the SSA request an exercise test. If your treating doctor has already had such testing done, it is important that the results be available to the SSA. Exercise testing is considered under adult Listing 3.02. There is no child listing for exercising testing.

5. Sleep-Related Breathing Disorders

A sleep-related breathing disorder, or sleep apnea, is associated with a drop in arterial blood oxygen, and often leads to awakening from sleep. Sleep apnea can be fatal if it interferes with your heart's ability to beat in a regular rhythm, a possibility that is increased with co-existent heart disease. Sleep apnea varies in degree of severity. Mild cases may involve only a few apneas per night of which you are unaware. In severe cases, you experience many apneas each night, waking often and sleeping so little that you can't think clearly the next day. Severe chronic sleep apnea can result in pulmonary heart disease. By far, the most common type of sleep apnea is that associated with obesity.

6. Episodic Respiratory Disease

Episodic respiratory illness means flare-ups of difficult breathing that may occur in people who have asthma (most common), cystic fibrosis or bronchiectasis. The attacks themselves may be associated with complications of pneumonia, coughing up blood, respiratory failure or bronchitis.

Whatever the nature of the attack and disorder that causes it, to qualify for disability you must provide the SSA with complete documentation of the attacks, including doctor and hospital treatment records. An episode that qualifies as attack has the following characteristics:

- Prolonged symptomatic episodes lasting one or more days.
- Need for intensive treatment—intravenous drugs (antibiotics, corticosteroids or bronchodilators) or inhaled bronchodilator drugs. Injection of drugs under the skin (such as subcutaneous epinephrine) does not qualify as an intensive treatment.
- Drugs administered in an emergency room, hospital or equivalent setting. Treatment in a doctor's office does not qualify.
- Inpatient (not emergency room) hospital admissions for longer than 24 hours.

7. Effects of Obesity

The combined effects of obesity and respiratory impairments can be greater than the effect of each of impairment considered separately. Therefore, when the SSA determines whether an obese person with breathing problems has a listing-level impairment or combination of impairments, and when assessing an individual's RFC, the SSA must also consider the effects of obesity, not just the respiratory problems. For example, an obese person with lung disease

might be capable of less exertion than a person of normal weight with the same lung disorder.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 3.02: Chronic Pulmonary Insufficiency (Adults)

Chronic pulmonary insufficiency is a general term covering most types of breathing disorders, rather than a specific disease. Different parts of this listing require various pulmonary function tests—spirometry and ABGS. The SSA will send you and pay for any pulmonary function testing it thinks you need.

a. Listing Level Severity

To meet the listing, you must satisfy **A**, **B** or **C**.

A Chronic obstructive pulmonary disease due to any cause.

This listing evaluates the severity of obstructive lung diseases such as asthma, emphysema and chronic bronchitis by measuring the FEV1. The spirometry used to measure the FEV1 requires the ability to follow very simple instructions, and even frail people can perform the test. You will be asked to put on a nose clip, take as deep a breath as possible and then blow it out as hard and fast as you can through your mouth into a tube. The procedure will be repeated at least three times.

If the test results are at least 70% of normal expected values, the test will end there. Otherwise, you will repeat it three times, after inhaling a bronchodilator drug to see if the results improve. If the person administering your spirometry does not think you put forth maximum effort, you will be sent for repeat testing. You may also be sent for retesting if the testing facility did the spirometry incorrectly, and this frequently happens.

An FEV1 equal to or less than the values in Table I satisfies the listing. Because taller people tend to have

higher FEV1 values, height is taken into account. If you have a spinal deformity, the SSA substitutes distance between the fingertips with outstretched arms for height. Although sex and age also affect FEV1 values, these are not considered. In using Table I, the SSA will use your highest FEV1, whether before or after bronchodilators.

Table I

Height without shoes (centimeters)	Height without shoes (inches)	FEV1 equal to or less than (liters)
154 or less	60 or less	1.05
155–160	61–63	1.15
161–165	64–65	1.25
166–170	66–67	1.35
171–175	68–69	1.45
176–180	70–71	1.55
181 or more	72 or more	1.65



If you have been told you have active tuberculosis (TB), SSA should not schedule you for spirometry until the infection is controlled. Active TB can contaminate a spirometer and pass the infection on to other people who are tested after you, unless special sterilization techniques of all the equipment are used. Some spirometers are not safely usable again, if infected with TB. Also, if you have active TB, healthcare personnel need to be able to take special precautions to avoid acquiring infection from you. If you just have a positive skin test (PPD) for TB, that does not in itself mean the presence of active TB in your lungs or elsewhere in your body.

- Ⓑ Chronic restrictive ventilatory disease due to any cause. This listing evaluates the severity of restrictive breathing disorders such as might be caused by pulmonary fibrosis, gross obesity, chest or spinal deformities, lobectomy or pneumonectomy, pneumoconiosis or other disorders, by measuring the FVC. The spirometry comments discussed above in part Ⓐ apply here. Because the FVC and FEV1 are measured from the same tracings, no extra testing is required to obtain both values. Some restrictive breathing disorders are evaluated under Part Ⓒ if granting benefits doesn't occur under part Ⓑ. (See below.)

Table II provides the FVC values necessary to satisfy part Ⓑ of the listing. As with part Ⓐ, if you have a spinal deformity, the SSA substitutes distance between the fingertips with outstretched arms for height.

Table II

Height without shoes (centimeters)	Height without shoes (inches)	FEV1 equal to or less than (liters)
154 or less	60 or less	1.25
155–160	61–63	1.35
161–165	64–65	1.45
166–170	66–67	1.55
171–175	68–69	1.65
176–180	70–71	1.75
181 or more	72 or more	1.85

- Ⓒ Chronic impairment of gas exchange due to clinically documented pulmonary disease. This listing evaluates the severity of some restrictive breathing disorders and some cases of advanced emphysema by measuring gas exchange—the ability of the lungs to release carbon dioxide waste gas from the bloodstream and absorb oxygen from the air. The tests used are DLCO and ABGS. Gas exchange problems will be seen in impairments like pulmonary fibrosis and pneumoconiosis, which involve direct lung damage if the disease is advanced. Restrictive breathing disorders that do not involve damage to lung tissue itself, such as spinal or chest deformities, obesity, lobectomy or stroke, will not have decreased gas exchange. To meet listing Ⓒ, you must have 1, 2 or 3.

1. Single breath DLCO less than 10.5 ml/min/mm Hg or less than 40% of the predicted normal value. DLCO is expressed as milliliters of carbon monoxide per minute per millimeter of mercury pressure that can diffuse through the lung, commonly written ml/min/mm Hg. Predicted normal values of DLCO vary according to age, sex and height. Doctors refer to standard tables to find predicted normal values, and such values are included on DLCO test reports. Generally, only hospitals have the kind of equipment and skills to perform DLCO testing.
2. ABGS values of oxygen pressure (PaO₂) and carbon dioxide pressure (PaCO₂) measured at least twice at rest (awake, and sitting or standing) and twice breathing room air. The tests must be done at least three weeks apart but within a six-month period.

The results must be equal to or less than the values specified in the applicable Table III-A, Table III-B or Table III-C, below. As the altitude at which a person lives increases, the lower pressure of oxygen in the air means that normal arterial oxygen pressure

decreases, and normal arterial carbon dioxide pressure increases. That is why different tables are used. They show the levels of oxygen and carbon dioxide pressures necessary to satisfy the listing, depending on the altitude of the laboratory that did the test.



If you have an ABGS test, make sure of the following:

- The person intending to stick a needle in your radial artery first tests the blood flow from the other artery in your wrist so that in the unlikely event your radial artery is damaged you will still have blood flow to your hand. This first test is quick, easy and harmless.
- Once the arterial blood sample is obtained and the syringe removed, insist that the person who took the blood apply direct pressure over the puncture site for at least five minutes; if you are on anti-coagulation drugs that make your blood thinner than normal, the time should be longer. Do not let the technician put on a bandage until he has applied pressure for the required amount of time and you are not bleeding.

The SSA should not send you for an ABGS unless you do not qualify for disability based on your FVC or DLCO. The DDS might try to schedule you for an ABGS along with spirometry to obtain your FVC and DLCO. If so, refuse the ABGS until the DDS or SSA assures you that your claim cannot be granted without the ABGS.

3. ABGS values of oxygen pressure (PaO_2) and carbon dioxide pressure (PaCO_2) measured during exercise and while breathing room air. A catheter must be inserted into your radial artery to obtain accurate results of ABGS during exercise. The purpose is to identify people who show a marked fall in arterial oxygen with exercise.

To qualify for disability, your ABGS must be equal to or less than the values specified in the applicable Table III-A, Table III-B or Table III-C. The tables measure low levels of exercise. Exertion put forth on exercise tests is measured in METs. A person sitting quietly is using about one MET. Sedentary work requires five METs' exertion, and the inability to do at least five METs of exercise without significant drops in arterial oxygen will qualify you under this listing.

Table III-A, Applicable at Test Sites Less Than 3,000 Feet Above Sea Level

Arterial PCO_2 (mm Hg)	AND	Arterial PO_2 Equal to or Less Than (mm Hg)
30 or below		65
31		64
32		63
33		62
34		61
35		60
36		59
37		58
38		57
39		56
40 or above		55

Table III-B, Applicable at Test Sites 3,000–6,000 Feet Above Sea Level

Arterial PCO_2 (mm Hg)	AND	Arterial PO_2 Equal to or Less Than (mm Hg)
30 or below		60
31		59
32		58
33		57
34		56
35		55
36		54
37		53
38		52
39		51
40 or above		50

Table III-C, Applicable at Test Sites Over 6,000 Feet Above Sea Level

Arterial PCO_2 (mm Hg)	AND	Arterial PO_2 Equal to or Less Than (mm Hg)
30 or below		55
31		54
32		53
33		52
34		51
35		50
36		49
37		48
38		47
39		46
40 or above		45

b. Residual Functional Capacity

Generally speaking, if your breathing test values are at least 80% of what would be expected of a normal person, you would have no pulmonary restrictions and would not qualify for an RFC.

In any other situation, your RFC should restrict you from working around excessive dust and fumes. For example, the SSA should not tell you that you can work in agricultural jobs involving exposure to excessive grain dust; heavy construction work involving driving bulldozers and similar equipment where you could be exposed to excessive dust and fumes; mining jobs that expose you to excessive coal or rock dust; or industrial jobs where you might be exposed to excessive chemical fumes. If you have done work involving exposure to excessive dust or fumes that caused your breathing problems, such as coughing or shortness of breath, make sure the SSA knows. Also tell the SSA about other environmental factors, such as extreme heat or cold, that cause your breathing problems to worsen.

Most RFCs for breathing disorders also involve exertional restrictions regarding how long you can stand and walk, lift and carry. There are no exact rules, but values closer to the listing should get lower RFCs. For example, if you have chronic obstructive lung disease, are 63 inches in height and have an FEV1 of 1.15 liters or lower, you would meet the listing. It is also reasonable that if your FEV1 is 1.3 liters—close to the listing—you should receive an RFC for no higher than sedentary work with avoidance of excessive dust and fumes.

Similar judgment should be applied to the restrictive breathing disorders and the various types of tests—FVC, DLCO and ABGS—used to evaluate severity. But remember that the SSA makes decisions based on all the facts in your case—lab test results, physical and x-ray abnormalities, your symptoms and the nature and severity of any other impairments you might have. Heart disease is particularly important in increasing limitations imposed by lung disease, because the heart and lungs are closely dependent on each other. Medical judgment must be carefully applied case by case.

2. Listing 103.02: Chronic Pulmonary Insufficiency (Children)

The comments under Listing 3.02 regarding spirometry and testing procedure warnings apply here. Bronchopulmonary dysplasia is the most common breathing disorder in children that the SSA sees that falls under this listing. Asthma in children is also very common, so common, in fact, it has its own listing (Listing 103.03). This listing usually requires detailed records of the child's medical treatment, including

hospitalizations. Children can do spirometry or other pulmonary function studies by about age six.

a. Listing Level Severity

To meet the listing the child's condition must satisfy **A**, **B**, **C**, **D**, **E**, **F**, **G** or **H** below.

A Chronic obstructive pulmonary disease due to any cause. Table I gives the FEV1 values necessary to satisfy part **A** of the listing. If your child has a spinal deformity, the SSA substitutes the distance between the child's fingertips with outstretched arms for height.

Table I

Height without shoes (centimeters)	Height without shoes (inches)	FEV1 equal to or less than (liters)
119 or less	46 or less	0.65
120–129	47–50	0.75
130–139	51–54	0.95
140–149	55–58	1.15
150–159	59–62	1.35
160–164	63–64	1.45
165–169	65–66	1.55
170 or more	67 or more	1.65

B Chronic restrictive ventilatory disease due to any cause. Table II gives the FVC values necessary to satisfy part **B** of the listing. If your child has a spinal deformity, the SSA substitutes the distance between the child's fingertips with outstretched arms for height.

Table II

Height without shoes (centimeters)	Height without shoes (inches)	FEV1 equal to or less than (liters)
119 or less	46 or less	0.65
120–129	47–50	0.85
130–139	51–54	1.05
140–149	55–58	1.25
150–159	59–62	1.45
160–164	63–64	1.65
165–169	65–66	1.75
170 or more	67 or more	2.05

- Ⓒ Frequent need for either 1 or 2. While “frequent” is not defined by the SSA and is a matter of medical judgment, it is unlikely that once a week or less could reasonably qualify.
 1. Mechanical ventilation.
 2. Supplemental oxygen during sleep.
- Ⓓ The presence of a tracheostomy in a child under three years of age.
- Ⓔ Bronchopulmonary dysplasia characterized by any two of the following:
 1. Prolonged expirations.
 2. Wheezing, flaring and tachypnea.
 3. Chest x-ray, CT scan or MRI scan showing hyperinflation or scarring of lungs.
 4. Dependency on bronchodilators or diuretics.
 5. A frequent need for supplemental oxygen during sleep.
 6. Weight disturbance (an indicator of a severe chronic disease) with a or b.
 - a. Involuntary weight loss (or failure to gain weight at an appropriate rate for age). This involuntary weight loss must result in a fall of at least 15 percentiles on standard growth charts, which lasts at least two months.
 - b. Involuntary weight loss (or failure to gain weight at an appropriate rate for age). This involuntary weight loss must result in a fall to below the third percentile on standard growth charts, which lasts at least two months.
- Ⓕ Two required hospital admissions, each longer than 24 hours, within a six-month period for recurrent lower respiratory tract infections (that is, something more serious than merely bronchitis) or acute episodes of difficulty breathing associated with 1 or 2. The cause of the hospitalization must be related to 1 or 2, not some other impairment.
 1. Chronic wheezing or chronic difficulty breathing.
 2. Weight disturbance with a or b.
 - a. Involuntary weight loss (or failure to gain weight at an appropriate rate for age). This involuntary weight loss must result in a fall of at least 15 percentiles on standard growth charts, which lasts at least two months.
 - b. Involuntary weight loss (or failure to gain weight at an appropriate rate for age). This involuntary weight loss must result in a fall to below the third percentile on standard growth charts, which lasts at least two months.

- Ⓖ Chronic hypoventilation as demonstrated by a PaCO_2 greater than 45 mm Hg, or chronic cor pulmonale as described under Listing 104.02 in Chapter 19. This listing deals with breathing disorders that involve decreased ability to move air in and out of the lungs; if such ventilation ability is severely impaired, the child will suffer from increased difficulty removing carbon dioxide waste gas from the blood and PaCO_2 will increase to abnormal levels.
- Ⓗ Growth impairment as described under the criteria in Listings 100.02 or 100.03 in Chapter 16.

3. Listing 3.03: Asthma (Adults)

Asthma is a common obstructive breathing disorder in both adults and children. The bronchial tubes have muscles in them which can open the bronchi wider by relaxing or make them smaller by contracting. Asthmatics have an abnormal tendency of their bronchi to contract. The lining of their bronchi may also become inflamed and swell which can produce more narrowing. Attacks can occur when asthmatics inhale irritating substances, inhale substances to which they are allergic, exercise, suffer emotional distress, have exposure to cold air or sometimes for no obvious reason.

Many asthmatics are treated effectively with bronchodilator drugs (such as theophylline or albuterol) and anti-inflammatory drugs (such as corticosteroids or cromolyn sodium). When asthma cannot be controlled with drugs, it means it may have reached a disabling level. See the discussion of episodic respiratory disease under “General Information” at the beginning of this chapter.

Because asthma is an obstructive breathing disorder, the SSA evaluates it by the FEV1 as determined by spirometry. (See comments under Listing 3.02.) Asthma can often be very effectively treated. Many asthmatics can participate in strenuous sports; some have even been Olympic athletes.

a. Listing Level Severity

To meet the listing, you must satisfy Ⓐ or Ⓑ.

- Ⓐ Chronic asthmatic bronchitis satisfying the criteria for chronic obstructive lung disease in Listing 3.02A.
- Ⓑ Attacks of asthma requiring physician intervention, not controllable with prescribed treatment, and occurring at least once every two months or at least six times a year. An inpatient hospitalization for longer than 24 hours counts as two attacks. Medical records covering a period of at least 12 consecutive months must be available to the SSA for evaluation.

b. Residual Functional Capacity

In most obstructive breathing disorders, if your FEV1 is at least 80% of what would be expected of a normal person, you would have no pulmonary restrictions and would not qualify for an RFC. This is not true of asthma, however. You might breathe fine and do well on a spirometry test between asthmatic attacks, but still require an RFC because of the severity of attacks. All of the facts in your case—such as physical and x-ray abnormalities and your overall symptoms (wheezing, shortness of breath) must be considered. A good example of the SSA needing to consider all of the facts involves exertional asthma. If you have asthmatic attacks triggered by exertion, then the FEV1 done by a spirometry test while you are in a resting state won't fully reveal the severity of your impairment.

Your RFC should always restrict you from doing work around excessive dust and fumes, or near any other airborne substance that is known to trigger your attacks. For example, the SSA should not tell you that you can work in agricultural jobs involving exposure to excessive grain dust; heavy construction work involving driving bulldozers and similar equipment where you could be exposed to excessive dust and fumes; mining jobs that expose you to excessive coal or rock dust; or industrial jobs where you might be exposed to excessive chemical fumes. If you've done work involving exposure to excessive dust or fumes that caused your breathing problems, such as coughing or shortness of breath, make sure the SSA knows. Also tell the SSA about other environmental factors, such as extreme heat or cold, that cause your breathing problems to worsen.

No specific rules fit every case of asthma—medical judgment must be applied case by case. But the closer you are to satisfying the requirements of a listing, the lower your RFC should be.

4. Listing 103.03: Asthma (Children)

Asthma is described in the introduction to Listing 3.03.

a. Listing Level Severity

To meet the listing, the child's condition must satisfy ①, ②, ③ or ④.

- ① An FEV1 value equal to or less than the appropriate value specified in Table I of Listing 103.02.
- ② Attacks of asthma requiring physician intervention, not controllable with prescribed treatment, and occurring at least once every two months or at least six times a year. An inpatient hospitalization for longer than 24 hours counts as two attacks. Medical records covering a period

of at least 12 consecutive months must be available to the SSA for evaluation.

- ③ Persistent low-grade wheezing between acute asthma attacks or no extended symptom-free periods, and day-time and nighttime use of sympathomimetic bronchodilators. These include the potent beta-agonist class drugs such as albuterol (Ventolin, Proventil) and metoprolol (Alupent), but do not include the weaker drugs theophylline or cromolyn sodium. Your doctor or pharmacist can tell you what kinds of drugs your child is taking. You can also look them up in books on drugs in bookstores and libraries or online at www.pdr.net.

Additionally, 1 or 2 must be satisfied.

- 1. Persistent prolonged expiration with a chest x-ray or other imaging method (CAT scan, MRI scan) showing hyperinflation or peribronchial disease.
- 2. Short courses of treatment with corticosteroid drugs that average more than five days per month for at least three months during a 12-month period.

- ④ Growth impairment as described under the criteria in Listings 100.02 or 100.03. (See Chapter 16.)

5. Listing 3.04: Cystic Fibrosis (Adults)

Cystic fibrosis (CF) is a genetic disease resulting in difficulty clearing secretions from the lungs. People with CF are susceptible to frequent episodes of pneumonia and bronchitis, and to chronic lung damage. Despite the fact that research into new treatments for CF holds great promise, it remains a dangerous and debilitating disease with a high mortality rate before age 30. If you have CF, it is more likely than not that the SSA will allow you under this listing. Even if you don't have the exact requirements for any part of this listing, you may have a combination of problems of equivalent severity. Many CF sufferers have digestive system problems and nutritional problems such as weight loss. If so, the SSA must consider them. Also see the discussion of episodic respiratory disease under "General Information" at the beginning of this chapter.

a. Listing Level Severity

To meet the listing you must satisfy ①, ② or ③.

- ① An FEV1 value satisfying the values in Table I, below. FEV1 is measured by spirometry; for more information on spirometry, see the comments under Listing 3.02. If you suffer from a spinal deformity, the SSA substitutes the distance between the fingertips with outstretched arms for height.

Table I

Height without shoes (centimeters)	Height without shoes (inches)	FEV1 equal to or less than (liters)
154 or less	60 or less	1.45
155–160	61–63	1.55
161–165	64–65	1.65
166–170	66–67	1.75
171–175	68–69	1.85
176–180	70–71	1.95
181 or more	72 or more	2.05

- Ⓑ Episodes of bronchitis, pneumonia, hemoptysis or respiratory failure requiring physician intervention, occurring at least once every two months or at least six times a year. An inpatient hospitalization for longer than 24 hours counts as two attacks. Medical records covering a period of at least 12 consecutive months must be available to the SSA for evaluation.
- Ⓒ Persistent pulmonary infection accompanied by additional recurrent, symptomatic episodes of bacterial infection occurring at least once every six months and requiring intravenous antibiotics or inhaled antibiotics delivered as a fine mist.

b. Residual Functional Capacity

In most obstructive breathing disorders, if your FEV1 is at least 80% of what would be expected of a normal person, then you would have no pulmonary restrictions and would not qualify for an RFC. This may not be true of CF, however, because of the possibility of chronic illness related to pulmonary infections and weight loss. Also, be sure to let the SSA know of all activities during a typical day devoted to prevention of worsening or the treatment of CF—such as physical therapy to help drain abnormal secretions from your chest, drugs taken and their side effects.

Your RFC should always restrict you from doing work around excessive dust and fumes or other airborne substances known to worsen your pulmonary symptoms. If you have done work involving exposure to excessive dust or fumes that caused you symptoms, such as coughing or shortness of breath, make sure you tell the SSA. Also let the SSA know about other environmental factors, such as extreme heat or cold, that affect your breathing.

No specific rules fit every case of CF—medical judgment must be applied case by case. But the closer you are to satisfying the requirements of a listing, the lower your RFC

should be. The relatively few adults with CF who don't qualify under the listings are usually restricted to an exertional level of no higher than sedentary work.

6. Listing 103.04: Cystic Fibrosis (Children)

Cystic fibrosis is described in the introduction to Listing 3.04.

a. Listing Level Severity

The meet the listing the child must satisfy part Ⓐ, Ⓑ, Ⓒ, Ⓓ or Ⓔ.

Ⓐ. An FEV1 value satisfying the values in Table II, below.

FEV1 is measured by spirometry; for more information on spirometry, see the comments under Listing 3.02. If you suffer from a spinal deformity, the SSA substitutes the distance between the fingertips with outstretched arms for height.

Table II

Height without shoes (centimeters)	Height without shoes (inches)	FEV1 equal to or less than (liters)
119 or less	46 or less	0.75
120–129	47–50	0.85
130–139	51–54	1.05
140–149	55–58	1.35
150–159	59–62	1.55
160–164	63–64	1.85
165–169	65–66	2.05
170 or more	67 or more	2.25

- Ⓑ For children in whom pulmonary function testing cannot be done (usually children under the age of six), the presence of any two of the following:
- History of dyspnea or accumulated secretions. Accumulated secretions may be assumed when the child suffers from repetitive coughing or cyanosis.
 - Persistent rales and rhonchi or a substantial decrease in the loudness of air moving in bronchi related to plugging of the trachea or bronchi.
 - X-rays showing extensive lung disease—seen as a thickening of the larger bronchial airways or the persistence of disease around bronchi in both lungs.
- Ⓒ Persistent pulmonary infection accompanied by additional recurrent, symptomatic episodes of bacterial infection occurring at least once every six months and

requiring intravenous antibiotics or inhaled antibiotics delivered as a fine mist.

- Ⓓ Episodes of bronchitis, pneumonia, hemoptysis or respiratory failure requiring physician intervention, and occurring at least once every two months or at least six times a year. An inpatient hospitalization for longer than 24 hours counts as two attacks. Medical records covering a period of at least 12 consecutive months must be available to the SSA for evaluation.
- Ⓔ Growth impairment as described under the child growth impairment Listings 100.02 or 100.03. (See Chapter 16.)

7. Listing 3.06: Pneumoconiosis (Adults)

Pneumoconiosis is a broad term for lung diseases caused by breathing small, dust-like particles into the lungs. Some possible causes of pneumoconiosis are excessive exposure to asbestos, rock dust (which can cause silicosis), coal dust (which can cause coal worker's pneumoconiosis) and metal dusts (including beryllium, barium, antimony, cobalt, tin or iron oxides). Although pneumoconiosis is often a fibrotic lung disease, it can also cause obstructive lung disorders. The SSA may require testing of the FEV1, FVC, ABGS or DLCO.

a. Listing Level Severity

To meet the listing, an appropriate imaging technique (such as chest x-ray, CAT scan or MRI scan) of the lungs must show pneumoconiosis. The severity of the pneumoconiosis is then evaluated under the applicable criteria in Listing 3.02.

b. Residual Functional Capacity

The RFC discussion for Listing 3.02 applies here.

8. Listing 3.07: Bronchiectasis (Adults)

Bronchiectasis is a serious chronic infection of some bronchial tubes, which can affect the surrounding lung tissue by causing pneumonia. Occasionally, antibiotics cannot cure the infection and surgical removal of a part of a lung is required. Few people qualify under this listing because treatment with antibiotics is usually effective. See the discussion of episodic respiratory disease under "General Information" at the beginning of this chapter.

a. Listing Level Severity

To meet the listing, an appropriate imaging technique (such as chest x-ray, CAT scan or MRI scan) of the lungs must

show bronchiectasis. Additionally, you must satisfy part Ⓐ or Ⓑ of the listing.

- Ⓐ The severity of the breathing impairment satisfies any of the criteria in Listing 3.02.
- Ⓑ Episodes of bronchitis, pneumonia, hemoptysis or respiratory failure requiring physician intervention, and occurring at least once every two months or at least six times a year. An inpatient hospitalization for longer than 24 hours counts as two attacks. Medical records covering a period of at least 12 consecutive months must be available to the SSA for evaluation.

b. Residual Functional Capacity

The RFC discussion for Listing 3.02 applies here.

9. Listing 3.08: Mycobacterial, Mycotic and Other Chronic Persistent Infections of the Lung (Adults)

Mycobacterial infections often involve common types of bacteria that cause tuberculosis (TB). Mycobacterial infections can also involve atypical types of bacteria, which tend to be very difficult to treat. TB's presence in the U.S. decreased for many years; however, a strain of TB that is resistant to all known drugs is spreading. TB can cause restrictive lung disease.



If you have been told you have active tuberculosis (TB), SSA should not schedule you for spirometry until the infection is controlled. Active TB can contaminate a spirometer and pass the infection on to other people who are tested after you, unless special sterilization techniques of all the equipment are used. Some spirometers are not safely usable again, if infected with TB. Also, if you have active TB, healthcare personnel need to be able to take special precautions to avoid acquiring infection from you. If you just have a positive skin test (PPD) for TB, that does not in itself mean the presence of active TB in your lungs or elsewhere in your body.

Mycotic infections are fungal infections such as blastomycosis, aspergillosis, histoplasmosis and candidiasis. Several drugs have been developed to treat mycotic infections. Untreated fungal infections or fungal infections that do not respond to treatment can cause restrictive lung disease.

Any other type of chronic persistent infection of the lungs can also potentially qualify under this listing. Such infections more often appear in chronically debilitated people whose immune systems are weakened, such as those who have AIDS or are undergoing chemotherapy for cancer.

a. Listing Level Severity

The severity of the impairment is evaluated under the criteria in Listing 3.02.

b. Residual Functional Capacity

The RFC discussion for Listing 3.02 applies here.

10. Listing 3.09: Cor Pulmonale Caused by Chronic Pulmonary Vascular Hypertension (Adults)

Cor pulmonale is heart disease caused by lung disease, specifically by pulmonary vascular hypertension. The right side of the heart pumps blood through the arteries of the lungs, which normally have little resistance to blood flow. Pulmonary hypertension puts strain on the right side of the heart because it has to pump blood against the abnormally high pressures in the blood vessels of the lungs. This can cause the heart to enlarge and potentially to go into failure.

a. Listing Level Severity

Clinical (physical or laboratory) abnormalities must show overloading or failure of the right ventricle of the heart, although complete right-sided heart failure is not necessary. Abnormalities acceptable to the SSA to show cor pulmonale are listed below. You don't have to have all of them, but the SSA should be able to conclude that cor pulmonale is present based on the abnormalities you do have:

- early diastolic right-sided gallop
- neck vein distention
- hepatomegaly
- enlargement of the right ventricular outflow tract, which may be seen on chest x-ray, CAT scan or MRI scan
- peripheral edema
- right ventricular hypertrophy seen on an EKG—the minor EKG abnormality called p-pulmonale is not evidence of cor pulmonale
- increased pulmonary artery pressure measured from cardiac catheterization
- hypoxemia.

Besides clinical evidence of cor pulmonale, you must satisfy ①, ② or ③, below.

- ① Average pulmonary artery pressure greater than 40 mm Hg. Pulmonary artery pressures must be obtained by cardiac catheterization, which is a test the SSA cannot require you to undergo—that is, the test must be done by your treating physician.

- ② Arterial hypoxemia as evaluated under Listing 3.02C2. This takes into account the possibility of associated low arterial oxygen levels.
- ③ Heart failure as evaluated under the criteria of Listing 4.02. (See Chapter 19.)

b. Residual Functional Capacity

If you don't meet the listing, the SSA should apply medical judgment case by case. The doctor will focus on your symptoms, especially shortness of breath on exertion and fatigue. You and your doctor must let the SSA know how these symptoms limit your activities of daily living. For example, do you get swelling in your feet if you stand too long? How long? Do you get short of breath or tired with a certain amount of exertion? How much? How long does it take you to walk a block? Are you unable to vacuum because of shortness of breath? Also list the environmental factors that make your symptoms worse—such as excessive dust and fumes, or extreme heat or cold. The more information the SSA has about your symptoms and limitations, the better the decision that it makes.

11. Listing 3.10: Sleep-Related Breathing Disorders (Adults)

Frequent episodes of cessation of breathing during sleep are usually obstructive sleep apnea, which is often related to obesity. One possible consequence of obstructive sleep apnea is pulmonary vascular hypertension, which can cause cor pulmonale. Central sleep apnea is less common and may be related to mental disorders involving brain damage.

Depending on whether the sleep apnea relates to cor pulmonale or a mental disorder, Listing 3.09 or Listing 12.02 (Chapter 27) may apply. Listing 12.02 deals only with mental disorders. A person with a mental disorder and central sleep apnea should be evaluated under both listings.

a. Listing Level Severity

The severity of the impairment is evaluated under Listing 3.09 or Listing 12.02, as appropriate.

b. Residual Functional Capacity

Two primary factors are evaluated in determining an RFC: the nature and severity of the disorder causing the sleep-related breathing disorder, and how much daytime sleepiness from disrupted sleep interferes with your ability to function. The SSA doctors should use medical judgment to determine your RFC.

If you have significant daytime sleepiness, it is particularly important that you do not drive, work at unprotected heights or work around hazardous machinery of any kind because of the risk to yourself or others. How long you can stand, walk or lift depends on the underlying diseases. If you suffer mainly from obesity, you could probably lift a significant amount of weight; if you have cor pulmonale, you may be able to lift only ten or 20 pounds.

12. Listing 3.11: Lung Transplant (Adults)

This listing deals with cases where one or both lungs may be transplanted, in an attempt to save a patient from terminal lung disease. In some instances, just one lobe (part) of one lung may have been transplanted. Rarely, heart-lung combination transplants have been done. Not everyone is a candidate for lung transplantation. Many are ineligible as a result of advanced age or co-existent medical conditions (like kidney failure) that would greatly decrease the chances of survival.

The one-year survival rate for double-lung transplants is 76%. For a single-lung transplant the rate is 75%. The most important factors affecting survival are the same as those for all organs transplants: immune rejection and infection. The reason infection is a problem is that the potent drugs used to keep the recipient's body from rejecting the new lung tissue also decrease immune resistance to many kinds of infection: bacterial, viral, fungal and parasitic.

Therapeutic drugs often result in significant complications, such as kidney failure and neurological toxicity. Corticosteroids, for example, can result in cataracts and osteoporosis.

Lung transplants require close monitoring for immune rejection and other complications, particularly infections. The first year after transplantation is particularly important, although problems can develop at any time.

a. Listing Level Severity

If you have had a lung transplant, the SSA considers you disabled for one year following surgery. After that, your residual impairment will be evaluated under whatever lung listings are appropriate.

The qualification for 12 months of disability benefits is automatic and comes with no restrictions whatsoever. For example, you could be feeling great eight months after surgery and your doctor could even tell the SSA she thinks you could work. But you would still qualify under the listing, if you choose to make use of it.

b. Residual Functional Capacity

Because your disability allowance is automatic, no RFC applies to lung transplants. After the requisite 12 months have elapsed, your case will be evaluated under whatever listings are appropriate to your particular circumstances. The SSA should be extremely hesitant to terminate your benefits unless you and your treating doctors think you are ready to return to some kind of work. Note that after a lung transplant, a person's exercise capacity is decreased for a period of years and may never return to normal.

13. Listing 103.11: Lung Transplant (Children)

The comments under Listing 3.11 apply here, even though the particular types of lung disease that may necessitate a transplant may differ in children.

a. Listing Level Severity

A child is considered disabled for one year following surgery and, as with an adult, no other medical factors can alter this qualification. After that year, the child's residual impairment is evaluated under whatever lung listings are appropriate. ■

Chapter 19

Heart and Blood Vessel Diseases

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

AK amputation. Above the knee amputation.

Akinesis. Absence of wall motion in a particular area of the heart. Usually evidence of a prior heart attack.

Aneurysm. Enlarged, weakened area in a body structure.

Angina pectoris. Chest pain caused by cardiac ischemia.

Angiography. Any technique to produce images of arteries, such as by x-rays or MRI scans. Usually involves injection of contrast material into the artery to make it visible. Also known as *arteriography*.

Ankle-brachial ratio (A/B Ratio). See *Doppler index (DI)*.

Annuloplasty. Surgery on the circular fibrous ring (annulus) that attaches a heart valve to the heart, as might be done to tighten a loose valve.

Anticoagulation. Drug treatment to slow the blood's clotting ability.

Aorta. Largest artery in the body, arising from the left ventricle of the heart and carrying blood to the entire body.

Aortic stenosis. Narrowing of the aortic heart valve.

Aortofemoral bypass grafting (AFBG). Surgery to restore blood flow to the legs by sewing artificial conduits around blockages in the aorta, iliac or femoral arteries.

Arrhythmia. Abnormality in the rate or rhythm of heart beats.

Arterial blood gases (ABGS). The measurement of oxygen gas pressure, carbon dioxide gas pressure, acidity and bicarbonate concentration in the blood. A sample of arterial blood is usually obtained in a syringe by needle puncture of the radial artery in the wrist.

Arteries. Blood vessels that carry blood away from the heart toward other tissues.

Arthralgia. Joint pain. Not the same as arthritis, which is disease affecting a joint. Arthralgia usually accompanies arthritis.

Ascites. Abnormal fluid accumulation in the abdomen. Advanced congestive heart failure is one possible cause of ascites.

Ataxic gait. Uncoordinated gait—inability to walk in a normal, smooth manner.

Atherosclerosis. General process of degeneration of the inner lining of arteries, particularly associated with fat and calcium deposits. Atherosclerosis is the major cause of coronary artery disease and peripheral vascular disease.

Atresia. Failure of an organ or tissue to develop during embryonic life. For example, failure of the aortic valve of the heart to develop is known as *aortic valve atresia*.

Atria. The smaller two chambers of the heart, consisting of the right and left atrium. The atria sit on top of the larger, ventricular chambers of the heart.

Atrial fibrillation (AF). Arrhythmia arising from the atrial chambers of the heart. Uncontrolled atrial fibrillation can cause blood clots inside the heart. If such a clot is then pumped to the brain, it can block a cerebral artery and result in a stroke.

Atrial septal defect (ASD). Congenital heart disease characterized by an abnormal hole between the small atrial chambers of the heart.

A-V canal defects. Congenital heart disease characterized by ventricular and atrial septal defects occurring near the heart valves, usually causing valve malfunction.

A-V dissociation. A type of heart block so severe that there is no coordination between the beating of the atria and ventricles.

Bicycle ergometer. Stationary bicycle that is sometimes used for cardiac exercise testing. It is particularly useful for people who cannot walk on a moving treadmill because of balance or other problems.

BK amputation. Below the knee amputation.

Bradycardia. Abnormally slow heart rate. Bradycardia is said to be present with any heart rate less than 60 beats/minute in adults. Normal heart rate is age-dependent in children.

Brawny edema. Swelling of the legs in chronic venous insufficiency caused by water and protein seepage from stagnant venous blood.

Bronchitis. Inflammation of bronchial airways; may be associated with infection or other sources of irritation such as allergy, smoke or chemical fumes.

Bypass graft. Conduit to carry blood around blockages in arteries. Grafts may be segments of arteries, veins or artificial materials.

Cardiac catheterization. Insertion of hollow tubes (catheters) into the heart. May involve ventriculography or coronary angiography (procedure for visualizing coronary arteries, usually by injecting x-ray contrast material into a coronary artery during cardiac catheterization) for treatment purposes, pressure readings or x-rays. Pressure readings can also be made in the pulmonary arteries and aorta.

Cardiac enzymes. Chemicals released into the blood as a result of heart muscle damage. Creatine phosphokinase (CPK), lactic dehydrogenase (LDH), cardiac troponin T (cTnT) and cardiac troponin I (cTnI) are types of cardiac enzymes.

Cardiac ischemia. Decreased blood flow to a part of the heart muscle, usually as a result of coronary artery disease. Also known as *myocardial ischemia*.

Cardiac syncope. Loss of consciousness as a result of heart disease.

Cardiomegaly. Enlargement of the heart. When measured on chest x-ray, expressed as *cardiothoracic (CT) ratio*. May be due to either increased heart muscle thickness or increased size of the heart's chambers.

Definitions (continued)

Cardiomyopathy. Any disease of heart muscle. Many things can cause cardiomyopathies including ischemia, viruses, drugs, alcohol and autoimmune disorders like systemic lupus erythematosus (SLE).

Cardiothoracic (CT) ratio. Calculated by dividing the width of the heart by the width of the chest. Normal adults do not have a CT ratio of over about 50%. For purposes of the listings, children one year old or less are considered to have cardiomegaly with a CT ratio over 60%. For children over age one year, the CT ratio must be at least 55% for cardiomegaly to be considered present on standard chest x-rays.

Cardiovascular. Reference to the heart and system of blood vessels.

Cardioversion. Treatment of arrhythmia by restoration of normal heart rhythm through delivery of an electrical shock.

Carditis. Inflammation of the heart.

Cerebral perfusion. Blood flow to the brain.

Chorea. Involuntary jerking motion of the limbs. May be associated with neurological disorders, as well as rheumatic fever.

Coarctation of the aorta. Congenital disorder characterized by narrowing in a part of the aorta.

Computerized axial tomography (CAT or CT) scan.

X-rays taken under computer guidance that can show much greater detail than regular x-rays.

Conduction system. The network of nerves in the heart that controls the timing and pattern of heart beats.

Congenital. Dating from birth. Congenital disorders may result from abnormal genes or some abnormality in the intrauterine environment before birth.

Contrast. Material that is injected during angiography, either for x-rays or MRI scans, to improve image quality.

Coronary arteries. Arteries that supply the heart itself with fresh blood. Of most interest are the larger coronary arteries that run near the surface of the heart, which become blocked in coronary artery disease. The major coronary arteries are the left main coronary artery, the left anterior descending coronary artery (LAD), the right coronary artery (RCA) and the left circumflex coronary artery (left Cx).

Coronary artery bypass grafting (CABG). Surgery to restore blood flow around blockages in the larger coronary arteries. Grafts for carrying the new blood supply can consist of segments of veins from the legs or can be made from the internal mammary artery in the chest.

Coronary artery disease (CAD). Partial or complete blockage of a coronary artery with abnormal deposits of fat, calcium and fibrous material. Although the coronary arteries can have diseases other than those involving fatty blockages, common use of the words "coronary artery disease" usually means disease associated with such fatty occlusions. Also known as *atherosclerotic heart disease (ASHD)*.

Costochondritis. Inflammation of the rib joints where they connect to the sternum (breastbone); a cause of chest pain not related to heart disease. Unlike heart disease, pressing on the chest will cause pain.

C-reactive protein. Nonspecific blood test for inflammation; tends to be high in infection such as rheumatic fever.

Critical aortic stenosis. Aortic stenosis so severe that it is life threatening.

Critical coarctation of aorta. Coarctation of aorta so severe that it is life threatening.

CT ratio. See *cardiothoracic ratio*.

Cyanosis. Bluish discoloration of the skin and mucous membranes that indicates inadequate oxygenation of tissues. It is most easily observed in the fingertips, toes, lips, earlobes and nose.

Deep venous thrombosis (DVT). Formation of blood clots (thrombi) in the deep system of veins in the lower extremities. If such clots move to another location, they are called emboli. For example, blood clots from the legs that move into the lungs are referred to as pulmonary thromboemboli.

Diaphragm. Muscular sheet separating the chest and abdominal cavities; important in breathing.

Diastole. Part of heart cycle during in which the heart is at rest (relaxed), and filling with blood.

Diastolic blood pressure. Pressure inside arteries during the time between heart beats. The diastolic pressure is the second number in a blood pressure reading. For example, 120/80 means the diastolic blood pressure is 80 mm Hg.

Digitalis. Any one of the digitalis glycosides, especially digoxin or digitoxin. Digitalis has always had an important role in the treatment of heart failure and the arrhythmia known as atrial fibrillation.

Dissection (of aneurysm). Tear and bleeding into the inner wall of an artery, in association with an aneurysm. Most commonly seen with aortic aneurysms.

Doppler index (DI). Method of expressing the amount of blood flow to the legs by dividing the systolic blood pressure in the ankle by that in the arm. The Doppler index is also known as the *ankle-brachial ratio (A/B ratio)*.

Doppler ultrasound. Imaging method that uses high-frequency sound and the Doppler principle to measure blood flow. Color Doppler ultrasound allows additional determination of the direction of blood flow.

Dyskinesis. Wall motion abnormality of heart, characterized by an outward bulging of a diseased area while the surrounding healthy muscle contracts.

Echocardiography. Any of the methods of imaging the heart using high-frequency sound (ultrasound). Results are called *echocardiograms*, because the sound bounces off of the heart and returns to a receiver in the transducer used to produce it. The "echoed" sound can then be used to make images. There are many types of echocardiography, such as M-mode, two-

Definitions (continued)

dimensional (2-D), three-dimensional (3-D) and color Doppler. M-mode echocardiograms can be useful in measuring heart valve sizes. 2-D and 3-D echocardiograms can provide useful information about the size and function of the heart's chambers. Color Doppler echocardiograms can show both the velocity and direction of blood flow through a heart valve—useful information in determining valve size and whether the valve provides a good seal when it closes.

Edema. Excessive fluid retention in a tissue, such as peripheral edema in the legs or pulmonary edema in the lungs.

Eisenmenger's physiology. Abnormal condition associated with a large and untreated ventricular septal defect (VSD). Consists of right to left shunting of blood through the VSD, right ventricular hypertrophy (thickening of the muscle of the right ventricle) and severe pulmonary hypertension. Also known as *Eisenmenger's complex*.

Ejection fraction (EF). Percentage of blood that a heart chamber can pump out when it contracts. The left ventricular ejection fraction (LVEF) is that from the left ventricle and the right ventricular ejection fraction (RVEF) is that from the right ventricle. When medical reports say "ejection fraction," they usually mean the left ventricular ejection fraction. A normal LVEF is about 55%. Decreased ejection fractions indicate poor function of a ventricle, such as from a heart attack or other disease. Ejection fractions can be measured by cardiac catheterization, radionuclide studies and echocardiography.

Electrocardiogram (EKG, ECG). Recording of the heart's electrical activity on the surface of the chest. A standard EKG uses 12 electrodes that record from different electrical positions. In unusual circumstances, additional recording leads may be used such as a lead that is swallowed (esophageal lead).

Electrolytes. Electrically charged elements or chemicals with important functions that occur naturally in the blood. Examples of electrolytes are potassium, sodium, calcium, phosphate and magnesium.

Electrophysiologic studies (EPS). Exacting measurement and testing of the heart's electrical activities by electrodes placed within the heart during cardiac catheterization. EPS are sometimes needed to find out the exact nature of an arrhythmia in regard to its origin in the heart, how it is triggered and how it can be stopped.

Endocarditis. Infection inside the heart.

Erythema marginatum. A rash that can be associated with streptococcal infection, such as in rheumatic fever.

Erythrocyte sedimentation rate (ESR). Test that measures how quickly red blood cells settle; the faster the settling, the more abnormal the result. An elevated ESR indicates some type of inflammation, not one particular disease. A normal ESR is about ten mm/hr or less in men and 20 mm/hr or less in women, depending on the method used by the reporting laboratory.

Esophagitis. Inflammation of the esophagus, usually caused by the reflux of stomach acid into the esophagus.

Fixed perfusion defect. Area of heart muscle with no blood flow as seen on a radionuclide scan. Suggests an area of dead heart muscle—a heart attack at some time in the past.

Gallop. Abnormal heart sound heard with a stethoscope; suggests abnormality of the heart's ventricles. There are S3 and S4 gallops.

Gangrene. Death of soft tissues, associated with a loss of blood supply and possibly followed by bacterial infection. If there is no bacterial infection, it is called *dry gangrene*.

Gastritis. Inflammation of the inner lining of the stomach.

Heart attack. Death of a piece of heart muscle, as a result of insufficient blood flow to maintain life in the tissue. Also known as a *myocardial infarction (MI)*.

Heart block. Condition in which the nerve conduction system of the heart has difficulty transmitting electrical impulses. There are several types of heart block, such as left bundle branch block, right bundle branch block and first, second and third degree heart blocks.

Heart valves. Structures that open and shut to control the flow of blood within the heart and out of the heart. The four heart valves are the mitral, aortic, pulmonary and tricuspid. Artificial heart valves can be mechanical or made from the heart valve tissue of other animals.

Hematocrit (Hct). Percentage of red blood cells in a volume of blood. For example, a hematocrit of 50% means that half of the blood volume is made up of red cells. In men, a normal Hct is about 42–48% and in women about 38–44% at sea level. At high altitudes, normal values are higher. Also known as the *volume of packed red cells (VPRC)*.

Hepatomegaly. Enlarged liver of many possible causes, including congestive heart failure.

Hiatal hernia. Common disorder characterized by bulging of part of the stomach into the chest cavity through a weak area where the esophagus passes through the diaphragm.

High blood pressure. See *hypertension*.

Holter monitor. EKG recorder worn by a patient that permits continuous monitoring of heart rate and rhythm over prolonged periods of time during their normal daily activities. Also known as *ambulatory electrocardiography*.

Hypercyanotic spells. Episodes of increased cyanosis, resulting from decreased oxygenation of tissues. Characteristic of a type of congenital heart disease known as *tetralogy of Fallot*.

Hyperlipidemia. Excessive amount of blood fats (lipids). Such fats include cholesterol and triglycerides.

Hypertension. High blood pressure. The word "hypertension" is usually understood to mean *systemic* hypertension, which is high blood pressure in the arterial system of the body other than the lungs. Hypertension in adults is defined as any pressure of 140/90 or greater. In children, normal expected blood pressure varies with age. The arteries of the lungs are a special low-pressure system different than that of the rest of the body.

Definitions (continued)

High blood pressure inside the arteries of the lungs is called *pulmonary hypertension* or *pulmonary vascular hypertension*, and can only be measured with catheters inserted into a pulmonary artery.

Hypertrophic cardiomyopathy. Genetic disorder in which there is a disorganized thickening and enlargement of heart muscle.

Hypokinesia. Decreased movement in a particular area of the heart. Hypokinesia is frequently seen in the presence of cardiac ischemia.

Hypoplastic left heart syndrome. Congenital heart disease characterized by poor development of the left side of the heart.

Hypoxemia. Decreased oxygenation of arterial blood.

Infarction. Death of a piece of tissue, as a result of insufficient blood flow. See *myocardial infarction*.

Intermittent claudication. Pain in the lower extremities occurring with walking, and caused by ischemia of leg muscles. The pain is usually of an aching quality in the calves of the legs and resolves with several minutes of rest. Less commonly, the pain of intermittent claudication is in the thighs or pelvic area.

Iridocyclitis. Inflammation of the eye's iris and ciliary body (small muscle in the eye that changes the shape of the lens and the muscles of the iris that control the size of the pupil).

Ischemia. Inadequate arterial blood flow to a tissue.

Ischemic cardiomyopathy. Diseased heart muscle as a result of decreased blood flow. Also known as *ischemic heart disease*.

Left bundle branch block (LBBB). Type of heart block characterized by absent electrical conduction in the left bundle branch of nerves of the heart.

Left-to-right shunt. Abnormal direction of blood flow from left to right inside the heart; usually associated with some kind of congenital heart defect.

Left ventricle (LV). The heart's most powerful chamber; pumps blood through the aorta to the rest of the body.

Left ventricular end diastolic diameter (LVEDD). Maximum inside diameter of the left ventricular cavity, measured when the heart is relaxed between beats and filled with blood. Sometimes abbreviated to LVDD or EDD. Also known as the *left ventricular inside diameter during diastole (LVIDD)*.

Lipids. Blood fats.

Lymphadenopathy. Enlarged lymph nodes.

Magnetic resonance imaging (MRI). Method of producing pictures of internal body structures using magnetic fields and radiofrequency fields. MRI does not use x-rays or other radiation.

Meningitis. Inflammation of the any part of the membranes (meninges) covering the spinal cord and brain. There are many possible causes of meningitis.

MET. Metabolic equivalent. A way of measuring exercise capacity based on oxygen used per unit of body weight.

Sitting requires about one MET. Doing sedentary type work requires about five METs.

Migratory polyarthritis. Arthritis moving among multiple joints.

Multiform beats. Ventricular premature beats coming from more than one location in the heart.

Murmur. Abnormal sound heard within the heart and caused by the turbulent flow of blood, such as through a diseased heart valve. Some mild murmurs do not indicate heart disease.

Myocardial infarction (MI). Death of a part of the heart muscle; a heart attack.

Myocardial ischemia. See *cardiac ischemia*.

Myocarditis. Heart muscle inflammation.

Myocardium. Heart muscle.

Near syncope. Decreased awareness short of complete loss of consciousness.

Orthopnea. Shortness of breath when lying down, but not in the upright position. Orthopnea may result from pulmonary edema caused by congestive heart failure.

Oxygen saturation. See *pulse oximetry* and SaO_2 .

Oxygenation. Supply of oxygen to tissues.

Pacemaker. Battery-powered device, implanted under the skin, with electrodes running into the heart's chambers. Pacemakers are common and highly useful in controlling atrial fibrillation as well as keeping up heart rates in bradycardia (abnormally slow heart rate) resulting from heart blocks. Demand pacemakers adjust heart rates with exercise level.

Palpitations. Sensations in the chest of forceful, irregular or rapid heart beats.

PaO_2 . Oxygen pressure in arterial blood, expressed as millimeters of mercury (mm Hg). Normal value (at sea level) 80–100 mm Hg.

Paroxysmal nocturnal dyspnea (PND). Sudden shortness of breath awakening a patient from sleep. PND may be caused by pulmonary edema resulting from congestive heart failure.

Patent ductus arteriosus (PDA). Congenital heart disease characterized by failure of the ductus arteriosus to close after birth. The ductus arteriosus is a vessel that normally connects the aorta and pulmonary artery before birth.

Percentile. Method of comparing something (like height or weight) to normal expected values, in order to decide the probability that it is normal or abnormal. For example, a person with a weight in the 60th percentile is heavier than 60% of other people and lighter than 40% of other people.

Percutaneous transluminal coronary angioplasty (PTCA). Inflation of a catheter in the area of a coronary artery plaque to squeeze the fatty blockage out of the way, thereby restoring blood flow to the part of the heart served by that artery.

Perfusion defect. Area of the heart with poor blood flow on a radionuclide scan. Reversible defects appear with exercise or drug stimulation and disappear with rest, suggesting ischemia.

Definitions (continued)

Fixed defects do not change with exercise or drug stimulation and suggest a prior heart attack.

Pericarditis. Inflammation of the pericardial membrane that surrounds the heart. There are many possible causes of pericarditis.

Peripheral arterial disease. Any disease of the arteries in the arms or legs.

Peripheral edema. Swelling in the feet or legs caused by fluid retention.

Peripheral vascular disease. See *peripheral arterial disease*.

Plaque. Partial occlusion of an artery by fat, calcium and fibrous material. Also known as an *atherosclerotic plaque*.

Plasmapheresis. Method for removing substances from the blood. Some blood is withdrawn from the body. The liquid part of the blood (plasma) is separated from the cells by spinning in a centrifuge. Blood cells are reinjected along with fresh replacement plasma or albumin. Plasmapheresis is usually done on an outpatient basis. It can be used either to remove unwanted substances from blood (such as elevated cholesterol) or to harvest plasma blood components for donation to patients who need them.

P-R interval. The distance between the p wave and r wave on an EKG. Associated with rheumatic fever.

Prosthetic heart valve. Artificial heart valve.

Pulmonary edema. Abnormal accumulation of fluid within the lungs; when due to heart disease is a sign of advanced heart failure. Pulmonary edema can be seen on a chest x-ray.

Pulmonary hypertension. High blood pressure inside the arterial system of the lungs. *Primary* pulmonary hypertension is a rare disorder of unknown cause, and arises from the arteries of the lungs themselves. *Secondary* pulmonary hypertension is more common and results from diseases starting outside of the lungs' arterial system. Secondary pulmonary hypertension could be caused by lung disease such as emphysema, bronchopulmonary dysplasia or cystic fibrosis; it can also be caused by disorders outside of the lungs, such as certain forms of congenital heart disease that pump excessive blood through the lung.

Pulmonary thromboembolism. Blood clots pumped into the lungs from their abnormal formation elsewhere in the body, usually from the lower extremities.

Pulmonary vascular obstructive disease (PVOD). Any disorder of the arteries in the lungs causing increased resistance to blood flow. Results in pulmonary hypertension.

Pulse oximetry. Method of measuring oxygen saturation in the blood without having to take an arterial blood gas sample or insert anything into your artery. Done by attaching a small sensor to a finger or ear lobe.

Radionuclide scans (of heart). Use of radioactive isotopes introduced into the body to make images of the heart by emitting x-rays or gamma rays. Technetium and thallium radionuclides are the most widely used in medicine. Cardiac

radionuclide scans have a variety of names and specific procedural variations, but the purpose in all of them is to measure blood flow to the heart muscle and/or provide pictures of the way the heart's ventricles pump blood, especially the left ventricle. Examples of names of radionuclide scans are cardiac blood pool scan, rest and/or exercise MUGA, gated cardiac scan, radionuclide angiography (RNA), radionuclide ventriculogram and wall motion study.

Rheumatic fever. Collection of abnormalities associated with streptococcal bacterial infections in children.

Right bundle branch block (RBBB). Type of heart block preventing electrical conduction in the right bundle branch of nerves of the heart. Generally less serious than a left bundle branch block.

Right to left shunt. Abnormal direction of blood flow from right to left inside the heart, usually associated with some kind of congenital heart defect. See *Eisenmenger's physiology*.

Right ventricle (RV). Heart chamber that pumps blood through the lungs.

Room air (RA). Ordinary air, 21% oxygen. Seeing "RA" or "21% oxygen" in association with an arterial blood gas study means the patient was not receiving extra oxygen.

SaO₂. Oxygen saturation of arterial blood, as measured by oximetry. Normal value (at sea level) is 95–99%. SaO₂ is less accurate than arterial oxygen pressure (PaO₂) in evaluating blood oxygenation; it is more useful in noninvasive monitoring to detect changes in oxygenation.

Shortening fraction. Change in the size of the left ventricle when it contracts. A lower shortening fraction means poorer function of the heart's left ventricle.

ST segment. An important part of electrocardiograms (EKG, ECG) done at rest or as part of a stress test, because if it is elevated or depressed it may mean there is cardiac ischemia, a heart attack, pericarditis, hypokalemia (low blood potassium) or just a distortion by drugs like digitalis.

Stasis dermatitis. Skin inflammation and brownish discoloration caused by chronic venous insufficiency.

Stasis ulcers. Areas of dead skin tissue resulting from chronic venous insufficiency.

Stenosis. Narrowing. The word is most commonly used in reference to diseased heart valves and narrowing in arteries.

Stent. Device placed in a blood vessel to keep it open. Metal stents have proved useful in preventing coronary arteries from becoming blocked again after percutaneous transluminal coronary angioplasty (PTCA).

Stress test. Any procedure to put the heart under a stress to test its function, especially those that increase heart rate. Exercise stress tests such as treadmills and bicycle ergometry raise heart rate by physical exertion. Pharmacologic stress tests use drugs like dipyridamole and dobutamine to simulate the effects of exercise in those patients who cannot perform physical exertion for some reason. All forms of stress testing may include

Definitions (continued)

imaging of the heart with echocardiography or radionuclides, as well as monitoring EKG, blood pressure and heart rate.

Subcutaneous nodules. Small, hard lumps beneath the skin that are sometimes associated with rheumatic fever.

Substernal. Beneath the sternum (breastbone)—the classic location of the pain of angina pectoris.

Syncope. Loss of consciousness.

Systemic hypertension. High blood pressure in the general arterial system of the body, excluding the arteries of the lungs. When the word “hypertension” is used, it is usually in reference to systemic hypertension unless otherwise stated.

Systolic blood pressure. Pressure inside arteries during the time the heart is pushing blood into them by contracting. The systolic pressure is the first number in a blood pressure reading. For example, 120/80 means the systolic blood pressure is 120 mm Hg.

Tachycardia. Abnormally fast heart rate. In adults, tachycardia is present with any heart rate over 100 beats/minute. In infants and very young children, normal heart rate varies with age.

Tetralogy of Fallot. Common type of cyanotic congenital heart disease. In this disorder, the aorta is not placed correctly on the heart (overriding aorta), there is a ventricular septal defect, stenosis of the pulmonic heart valve and right ventricular hypertrophy (thickening of the muscle of the right ventricle).

Total anomalous pulmonary venous connection. Congenital heart disease in which the pulmonary veins that normally carry blood from the lungs to the left side of the heart connect instead to the right side of the heart. The vein connections are therefore “anomalous”—that is, abnormal. An atrial septal defect is an additional abnormality usually seen with this disorder.

Transposition of the great arteries. Congenital heart disease characterized by switching of the normal positions of the aorta and pulmonary arteries in relation to the heart, so that the aorta arises from the right ventricle and the pulmonary artery arises from the left ventricle—just the opposite of the normal condition.

Treadmill stress test (TST, TMST). Common type of stress test in which the patient walks on a moving platform that can be adjusted for grade (tilt) and speed. The amount of grade and speed can be gradually increased in *stages*. A number of available protocols determine the grade, speed and duration of each stage of a treadmill stress test. One is the Bruce protocol. The amount of exertion achieved in treadmill stress testing is expressed in METs. Completion of stage I of a standard Bruce protocol requires about five METs’ exertion; completion of stage II about seven METs; stage III about ten METs. During treadmill stress testing, the patient’s vital signs (heart rate, blood pressure and respiration) and overall condition are continuously monitored. So is an EKG for arrhythmias or ST segment changes indicative of cardiac ischemia.

Truncus arteriosus. Congenital heart disease in which a single artery arises from both the left and right ventricles of

the heart. In contrast, a pulmonary artery normally arises from the right ventricle and the aorta from the left ventricle. A ventricular septal defect is an additional abnormality always present with truncus arteriosus.

Ultrasound. Ultrasound means high-frequency sound. Ultrasound has wide application in the imaging of internal organs, such as echocardiography of the heart. Doppler ultrasound can be used to measure blood flow velocity and direction and blood pressure.

Valvotomy. Surgical incision into a heart valve, as when to open more (dilate) a narrowed valve. Also known as *valvulotomy*.

Valvular insufficiency. Blood flowing back through a heart valve that does not make a good seal when it closes.

Valvular regurgitation. See *valvular insufficiency*.

Valvuloplasty. Surgical repair of a heart valve, such as when a balloon-tipped catheter is inserted into a stenosed valve and inflated to increase the size of the valve (balloon valvuloplasty).

Variant angina. Angina that is caused by vasospasm of a coronary artery and is more often related to emotional stress than physical exertion.

Vasculitis. Inflammation of an artery.

Vasospasm. Contraction of muscles in the wall of an artery, causing it to narrow.

Veins. Blood vessels that carry blood to the heart.

Venography. Any technique to produce images of veins, such as by x-rays or MRI scans. Usually involves injection of contrast material into the artery to make it visible.

Venous insufficiency. Inability of damaged veins to adequately return blood from the legs. Abnormalities with venous sufficiency may include swelling of the legs, stasis dermatitis, varicose veins (enlargement of the superficial veins that can be seen just under the skin) and stasis ulcers—all caused by poor circulation of venous blood.

Ventricles. The heart’s main pumping chambers. Also see *left ventricle* or *right ventricle*.

Ventricular dysfunction. Decreased function of the heart’s ventricles; if marked, can result in congestive heart failure.

Ventricular premature beat (VPB). An abnormal heart arising from the heart’s right or left ventricle. Also known as *premature ventricular contraction (PVC)*.

Ventricular septal defect (VSD). Congenital heart disease characterized by an abnormal hole connecting the left and right ventricles.

Ventriculography (of heart). Evaluation of the function of the right or left ventricles by production of images—x-rays taken during cardiac catheterization, MRI scans of the heart or radionuclide scans of the heart. If done during catheterization of the heart, pressures inside the ventricles may also be measured.

Vital signs. Blood pressure, heart rate and respiratory rate.

Definitions (continued)

Wall motion. Motion of the heart's walls, especially of the walls of the ventricles. Wall motion is abnormal in areas of scarring where there have been heart attacks, areas of ischemia where blood flow is inadequate, and in other disorders that affect the health and function of the heart muscle. Wall motion may be seen on various heart imaging tests such as MRI scans, radionuclide scans, echocardiography and ventriculography done during cardiac catheterization. Wall motion imaging is extremely important in many stress tests.

Watt. Measure of energy needed to complete different levels of exercise on bicycle stress testing. When watts are used by the SSA as a measure of exercise ability, they are converted to the equivalent number of METs.

A. General Information

The SSA makes decisions about disability based on symptoms, physical signs, laboratory test abnormalities and responses to treatment. Regarding heart and blood vessel (cardiovascular) disease, the SSA requires medical records over a period of at least three months. The SSA believes that three months are needed to reach a diagnosis, decide the type of treatment and see how well you will respond. Sometimes, especially after multiple surgeries, the SSA needs six months to make an accurate decision.

Cardiovascular disease appears in five basic forms:

- disease of the coronary or peripheral arteries
- disease of the heart muscle
- disease of the nerves of the heart
- disease of the heart valves, and
- congenital heart disease.

Each one of these forms of heart disease can be disabling because it produces one or more of these limitations:

- chronic heart failure
- angina pectoris or intermittent claudication
- syncope or near-syncope caused by inadequate blood flow to the brain, or
- poor oxygenation of blood.

A further common consequence of the above four factors is exercise intolerance manifested by easy fatigability and shortness of breath.

a. Disease of the Coronary Arteries

The most common cause of heart disease in adults is coronary artery disease. Coronary artery disease develops from a combination of genetic predisposition and a diet with

a high fat content. When the coronary artery begins to block, blood flow to the heart will decrease. A significant decrease in the blood flow will occur when 70% of the artery is blocked. But even a 50% blockage of the left main coronary artery is considered dangerous because it affects other major coronary arteries.

Blood flow through a coronary artery doesn't have to be completely blocked by a fatty deposit (plaque) to cause a heart attack. Heart attacks are sudden, unpredictable events that can occur with relatively minor plaques, because of the additional formation of a blood clot that completely stops blood flow.

b. Disease of the Heart Muscle

Diseases of heart muscle, cardiomyopathies, have many different possible causes, including:

- decreased blood supply—ischemia or heart attacks
- viral infections
- poisons and toxins
- alcohol—alcoholic cardiomyopathy is common
- drugs
- parasites
- cancer, and
- genetics.

c. Disease of the Nerves of the Heart

The nerves that carry impulses to stimulate the heart muscle to contract in a certain pattern are vital to cardiac function. Nerves of the heart's conduction system can be susceptible to many disorders, including all of those mentioned above for cardiomyopathies.

Malfunction of the heart's conduction system can be manifested by various kinds of arrhythmias, as well as blocks to nerve conduction, such as left bundle branch block (LBBB), right bundle branch block (RBBB) and first, second and third degree atrioventricular (AV) heart blocks. Heart blocks can be seen on an electrocardiogram (EKG) and are identifiable by a doctor.

d. Disease of the Heart Valves

The heart has four valves that allow blood to flow one way through the heart. These valves sometimes become damaged by disease. One of the most frequent causes of valvular heart disease is infection, such as rheumatic fever in a child. Long after the rheumatic fever is gone—in fact, years later—residual damage can show up on one of the heart valves. When such damage occurs, it usually involves the mitral or aortic valves. Intravenous drug abusers risk infecting their tricuspid valve if they do not use clean needles and syringes.

Disease of any of the valves can cause failure of the heart's ability to pump blood adequately in one of two ways: either the valve becomes stenosed so that the heart has trouble pushing blood through it, or the valve has become incompetent so that blood flows in two directions. An incompetent valve is said to have valvular insufficiency. Valvular insufficiency causes regurgitation of the blood back through the valve in the wrong direction.

Prosthetic heart valves are highly effective in restoring cardiac function and alleviating symptoms. Operations on heart valves like annuloplasty and valvotomy can restore the function of some valves without requiring a prosthetic replacement.

e. Congenital Heart Disease

Most congenital heart disease is genetic. Congenital heart disease is a problem of substantial complexity because of the many possible malformations of the heart with different consequences. Congenital heart disease can be classified as cyanotic (involving inadequate oxygenation) or noncyanotic.

Common types of congenital heart disease are ventricular septal defect (VSD), tetralogy of Fallot and atrial septal defects. All of these diseases can usually be surgically corrected. Some VSDs are so small they don't require surgery. Failure to perform needed surgery on tetralogy of Fallot or large VSDs, however, can be fatal for a child. Similarly, a patent ductus arteriosus can have little effect on a person if it is small while a large one represents serious heart disease.

1. Heart Attacks

The SSA sees many applications for disability based on an allegation of a heart attack, but many people are confused about what this really means. Heart attacks are common and can be a serious cause of disability; you need to know a few basic facts about them and the various tests used to diagnose a heart attack.

To begin, the medical term for a heart attack is myocardial infarction (MI)—part of heart muscle tissue (myocardium) has been killed (infarcted) and replaced with scar tissue. It is important for you to understand that angina (chest pain) is not a heart attack. Angina related to cardiac ischemia is reversible and does not result in the death of myocardium.

Most heart attacks involve the heart's large left ventricle, which pumps blood through the arterial system of the body. It is possible to have heart attacks involving the right ventricle, but these are more unusual.

The SSA requires objective evidence of an MI before accepting your treating doctor's diagnosis. Generally, proof of an MI can be established several ways.

- *EKG abnormalities.* An EKG can show an old (remote) or a new (acute) MI. An EKG doesn't always show an MI, however, especially when the heart attack occurred in the distant past.
- *Cardiac enzymes.* Enzymes are chemicals released into the bloodstream from the heart when it is damaged from an MI. Enzymes rise during an acute MI—that is, when the heart attack is taking place. How high enzymes go is related to the size of the heart attack. Enzyme levels generally return to normal levels within about one week of an MI. Therefore, an enzyme blood test won't diagnose a heart attack that occurred years, or even months, earlier. The SSA needs the dates of the tests and enzyme values showing the specific enzyme blood concentrations. The SSA accepts the new enzyme test (troponins) as well as the old tests (LDH or CPK).
- *Radionuclide scans and ventriculograms.* Thallium and technetium studies of the heart can be used to diagnose heart attacks in one of two ways: video showing fixed perfusion defects where there is no longer blood flow, and video showing akinesis of where the heart muscle has died. The SSA needs the results of the tests, but not the actual films.
- *Cardiac catheterization.* Ventriculograms done during cardiac catheterization can show a heart attack by the presence of akinesis. Coronary artery blockages can verify the presence of the fatty blockages that are usually responsible for heart attacks. The SSA needs the results of the tests, but not the actual films.
- *Echocardiogram.* Echocardiograms can provide imaging of the ability of the heart's ventricles to contract. Akinesis in the left ventricle suggests scar tissue from a prior heart attack. The SSA needs the results of the tests, but not the images or tracings.

The degree of disability produced by a heart attack depends on how large it is and the severity of associated coronary artery disease. If an MI kills a large part of the heart muscle, the heart cannot function and death will occur. For example, a person with a heart attack that involves half of his heart muscle will not survive, while a person with a minor heart attack and little damage to the heart muscle might not even be considered disabled. The absence of coronary artery disease makes heart attacks unlikely, but vasospasm of an otherwise healthy coronary artery can, in rare instances, block blood flow long enough to cause a heart attack. Such vasospasm may be of unknown cause or induced by the use of cocaine.

2. Angina Pectoris

Angina is most frequently associated with coronary artery disease. Angina is pain caused by cardiac ischemia. Pain refers to any type of chest discomfort. If you have a claim for disability based on heart disease, you must understand angina and how it is evaluated by the SSA. Because angina is a symptom rather than something that can be directly measured, you must be able to accurately describe your chest pains.

Angina has the following general characteristics:

- **Location:** Substernal or central chest, radiating to the left arm. It is possible to have angina that is not in the center of the chest; it can occur in just the left arm, shoulder or jaw.
- **Quality:** Pain which is aching, dull, tight, squeezing or heavy. People use different terms to describe the quality of the chest pain. Disability applicants frequently use the word “sharp” because they can’t think of a better word. This word only confuses matters because angina is not generally considered a sharp or sticking pain. Most importantly, angina is never rhythmic. A rhythmic pain is one that rapidly changes on and off like a stabbing or jabbing or throbbing pain, or like pins and needles.
- **Cause:** Physical exertion or intense emotion. Angina is predictably related to exertion and emotion because a faster beating heart needs more blood flow and oxygen. But not all chest pain related to exertion and emotion is angina. If you do not get sufficient blood flow through diseased coronary arteries to your heart during exercise, the result is the release of chemicals inside the heart muscle that stimulates pain nerves to produce angina. On the other hand, chest pain occurring in a random relationship to exertion and emotion (where there is no predictable cause and effect) is probably not angina.
- **Relief:** Rest and nitrate drugs such as nitroglycerin. Just as exercise can cause angina, rest can decrease the heart’s need of oxygen and the chest pain disappears. In addition, certain nitrate drugs widen arteries to the heart and help relieve pain by improving blood flow to heart muscle.
- **Duration:** Three to five minutes. Longer episodes of chest pain are generally called *unstable angina*. Unstable angina is a medical emergency requiring treatment in a hospital.

Some claimants report chest pain that lasts for hours a day. The SSA will not accept such a claim as being angina pectoris. Unstable angina, which could last for hours, must be documented by hospital records. Even if you have un-

stable angina, the duration will decrease to a few minutes after treatment. And a person with unstable angina would not be discharged from a hospital until the unstable angina is controlled. Claimants who have chest pain lasting several hours per day are not having angina, especially if the episodes have been occurring for months or years.

If you are not sure how long your chest pain lasts, time some episodes with a watch. Just as chest pain lasting more than a few minutes is not likely angina, chest pain lasting less than one minute is usually not angina either. Nor are chest pains associated with twisting or turning movements, pushing on the chest, or coughing.



Often, medical records do not contain a complete description of chest pains.

If you have heart disease with angina and want to apply for disability, make sure you have carefully described your chest pain to your doctor and that your description is in your records. If your records are incomplete, the SSA may have to contact your doctor, which can delay your disability decision considerably. If your treating doctor refuses to provide the SSA with a description, you might have to undergo a consultative examination, which can also delay your decision. Also, the SSA needs a description that applies to your condition at the time the disability determination is being made—a chest pain description taken before you receive treatment might no longer apply.

Chest pain is one of the most difficult allegations for the SSA to evaluate because so many disorders can cause such pain, such as cracked ribs, pneumonia, arthritis in the neck, bronchitis, tumors, hiatal hernias, costochondritis, gastritis, peptic ulcers, pancreatitis, esophagitis, bile duct disease and spasms of the esophagus. Also, many treating doctors give an incomplete description of chest pain so the SSA has to send a claimant for a consultative examination.

Additionally, claimants frequently describe the pain differently to different treating doctors, and the doctors inside and outside of the SSA’s disability system. The bottom line: Pay close attention to the characteristics of your chest pain and try to not give multiple or conflicting descriptions.

3. Congestive Heart Failure

Congestive heart failure (CHF) means the underlying heart disease is so severe that the heart cannot keep up with pumping out the blood flowing into it. The resulting backed-up pressure causes fluid congestion of organs, such as pulmonary edema or congestion of the liver. Pulmonary edema can be heard as abnormal sounds (rales) in the chest with a stethoscope and can also be seen on chest x-ray. Through a stethoscope, a person with heart failure may have an abnormal sound called an S3 gallop. An enlarged

heart may be shown by a chest x-ray, echocardiography, radionuclide scan or MRI scan. An enlarged heart does not in itself imply the presence of heart failure.

CHF can be of all degrees of severity. Acute heart failure means heart failure present at the time of examination with signs of fluid congestion such as peripheral or pulmonary edema. Florid heart failure refers to obvious and severe acute heart failure. Chronic heart failure means the heart's pumping function remains limited enough that, even after treatment, significant symptoms of easy fatigability and shortness of breath with exertion remain even after treatment.

The SSA will want to know how well you have responded to whatever treatment has been given. Digitalis and angiotensin-converting enzyme (ACE) inhibitors are particularly important in the treatment of heart failure, as well as diuretics to decrease the fluid load on the heart. Digitalis is commonly used in the treatment of heart disease and can cause distortion of EKG results. Although you won't be trying to read your own EKG results, know that the SSA will be particularly interested in whether you are taking any form of digitalis.

4. Cardiac Stress Tests

The basic purpose of stress tests is to put some type of stress on the heart either to diagnose ischemic heart disease or to find out a person's exercise capacity. The importance of stress tests is that the heart may not reveal its difficulties in the resting state. The essence of all cardiac stress testing is to increase the heart rate and then try to find out if the heart is getting enough blood to the heart muscle at that heart rate.

There are two broad categories of stress tests:

- Exercise stress tests, such as walking on treadmills (measured in METs) and riding stationary bicycles (measured in watts). If the SSA wants to send you for a stress test, it requests an exercise test, usually a treadmill test.
- Pharmacologic stress testing, in which the heart is stimulated by drugs. These tests use echocardiography or radionuclide scans to detect abnormal wall motions of the heart under stress to diagnose cardiac ischemia. Dobutamine and dipyridamole are the most commonly used drugs in pharmacologic stress testing, but there are others.

The SSA should not ask you to undergo cardiac stress testing unless you cannot be granted benefits without such a test, because any stress testing has some risk. If you can't be allowed benefits in any other way, only a doctor should decide if stress testing is indicated or not. Disability examiners, case managers, disability hearing officers and other

medically unqualified individuals should never decide that you need a stress test or that it is safe for you to undergo such a test. Furthermore, the SSA should never schedule a stress test without also arranging for you to be thoroughly examined before. And a doctor should always be present during a stress test.

Situations in which you should not have a stress test include the following:

- heart attack within the past three months
- advanced heart failure
- cardiac drug toxicity
- uncontrolled serious arrhythmias
- uncontrolled severe systemic hypertension
- marked pulmonary hypertension
- marked stenosis of the aortic valve
- stenosis of 50% or more of the left main coronary artery
- dissecting aortic aneurysm that has not been surgically repaired
- recent pulmonary embolism
- musculoskeletal or neurological disorders that might interfere with your ability to safely perform testing, and
- significant acute illness, such as pneumonia.

The SSA should give great weight to the opinion of your treating doctor regarding whether it is safe for you to undergo stress testing. Rarely will the SSA ask you to undergo stress testing against the advice of your treating doctor. If your doctor cannot provide a reasonable medical basis for why you cannot undergo stress testing, however, the SSA can request such testing anyway.

Cardiac stress testing is infrequently performed in children, but the SSA may do so—subject to the same limitations for adults—if necessary to evaluate some arrhythmias, the severity of chronic heart failure or recovery of function following heart surgery or other therapy. Such testing usually cannot be performed in children under age six, and must be done by a facility qualified to perform exercise testing on children.

5. Peripheral Arterial Disease and Doppler Exercise Tests

Most of the peripheral arterial disease (PAD) responsible for disability is atherosclerosis of the arterial blood supply to the lower extremities. Decreased blood flow leads to the symptoms of intermittent claudication. Where possible, the most effective treatment of PAD is surgery to insert grafts that carry blood around the blockages. If surgery has been done, the SSA will generally need at least three months to properly evaluate the outcome.

The presence and severity of PAD can be diagnosed with angiography showing blockages in the arteries. The SSA cannot order an angiography on the arteries to your legs because it is invasive, requiring the insertion of a catheter into the aorta and the injection of x-ray contrast material. If angiography is called for, your treating doctor must do it.

Another way to determine the severity of PAD is to use a Doppler transducer to measure the systolic blood pressure in peripheral arteries. If you won't be given benefits in any other way, the SSA may ask that you undergo Doppler measurements of blood pressure in your legs with exercise. Although the goal is to evaluate blood flow in the legs with exercise, the same precautions must be taken as discussed above with a cardiac stress test. If you need exercise Dopplers, you'll be asked to walk on a treadmill at two miles per hour on a 10% or 12% grade for five minutes. The doctor will measure the blood pressure in your arm and ankle arteries before and right after exercise.

Doppler studies apply only to diseases affecting the larger arteries. Doppler ultrasound cannot measure the severity of disease in small arteries, as occurs with diabetes.

6. Effects of Obesity

The combined effects of obesity and cardiovascular impairments can be greater than the effect of each impairment considered separately. Therefore, when the SSA determines whether an obese person with breathing problems has a listing level impairment or combination of impairments, and when assessing the RFC, the SSA will consider the effects of obesity. For example, a significantly overweight person with heart or peripheral vascular disease might be capable of less exertion than a person of normal weight with the same disorder.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 4.02: Chronic Heart Failure (Adults)

The most frequent causes of adult chronic congestive heart failure (CHF) seen by the SSA are coronary artery disease and alcoholic cardiomyopathy. Early alcoholic damage to the heart can substantially improve with abstinence from alcohol. Some degree of reversibility may also be present with viral infections of the heart.

Patients with heart failure because of heart valve disease can often be returned to good cardiac function with an artificial valve replacement. Similarly, some forms of congenital heart disease can be markedly improved with surgery, such as patching the hole that is a ventricular septal defect or atrial septal defect. Congenital heart disease is covered in Listing 4.06.

Most cases of CHF can be improved with medical treatment, but the underlying disease may still be present. In such cases, return to completely normal functional ability will not occur. The prognosis for CHF caused by ischemic heart disease is poor—as high as 50% mortality per year in some cases.

The absence of heart failure after treatment is known as compensated heart failure. If, on the other hand, signs and symptoms of heart failure remain after treatment, you have chronic heart failure or partially compensated heart failure. Because most cases of CHF are caused by ischemic heart disease, the possible presence of angina pectoris must always be considered. Chronic heart failure is functionally limiting because of symptoms of dyspnea, especially with exertion, and fatigue that interfere with activities of daily living without frequent rest periods, even without angina.

To show chronic heart failure, the listing does not require signs of fluid retention such as pulmonary edema, hepatomegaly, ascites or peripheral edema at the time you apply for disability. But your medical records must document signs of vascular congestion at some point in time.

a. Listing Level Severity

Once heart failure at some time has been established, you must satisfy ①, ② or ③ to show some significant degree of chronic heart failure.

① Current cardiac enlargement documented by either of the following:

- Cardiothoracic (CT) ratio of greater than 50% (0.50) on a PA (posterior-anterior or back-to-front) chest x-ray showing good inspiration. Good inspiration is required because failure to take a deep breath during the x-ray will make the heart appear falsely enlarged.
- Enlargement of the left ventricular end diastolic diameter (LVEDD) as measured by two-dimensional (2-D)

echocardiography of greater than 5.5 centimeters.

This is much more accurate than the CT ratio.

In addition to current cardiac enlargement and acute heart failure at some point in time, the SSA needs documentation of recurrent or persistent symptoms that suggest continuing inability of the heart to adequately pump blood (low cardiac output). The symptoms must be severe enough to result in inability to carry on any physical activity. Symptoms to be expected are recurrent or persistent fatigue, shortness of breath with any exertion, orthopnea or angina occurring at rest.

ⓑ This listing applies to cases in which exercise testing has been done. To qualify, one of the following must be present:

- Cardiac enlargement as described under part Ⓐ.
- Poor function of the left ventricle of the heart, demonstrated by an S3 gallop heard with a stethoscope, abnormal wall motion of the left ventricle or left ventricular ejection fraction (LVEF) in the upper 30% range. Abnormal wall motion could be akinesis, dyskinesis or hypokinesis. A decreased LVEF and wall motion abnormalities can be observed with a number of imaging techniques such as ventriculography done during cardiac catheterization, radionuclide scan, echocardiography or MRI.

In addition, you must satisfy 1 and 2:

1. Inability to perform on an exercise test at a workload equivalent of five METs or less, due to symptoms of chronic heart failure, or, in rare instances, a need to stop exercise testing at less than this level of work because of a, b or c:
 - a. Three or more consecutive ventricular premature beats or three or more multiform beats.
 - b. Failure to increase systolic blood pressure by at least 10 mm Hg, or a decrease in systolic blood pressure below the usual resting level.
 - c. Signs of inadequate cerebral perfusion, such as ataxic gait or mental confusion.

The SSA should not consider that you successfully did five METs of exercise, unless you actually completed the entire stage of whatever exercise protocol was being used. For example, Stage I of the standard Bruce protocol, frequently used by the SSA, is considered to be five METs for disability determination purposes. Stage I is supposed to last three minutes. If you could only exercise two minutes, then you could not complete Stage I and so would qualify under ⓑ1, if the other requirements were also satisfied. You can easily check this yourself, by asking the following question of the doctor who performed the test—"How many METs did I

achieve and did I exercise for the full duration of that stage of the test?" Or you should be able to get a copy of the exercise test report from your doctor or hospital. The type of protocol should be listed with the speed and grade of each stage, as well as how long you exercised at each stage, along with your vital signs, comments on any symptoms you may have had, and the doctor's interpretation of whether your EKG tracings were abnormal.

2. Marked limitation of ordinary physical activity by symptoms such as palpitations, fatigue, dyspnea or angina. These are symptoms that occur during your daily life, not on an exercise test. Your symptoms should require you to decrease your activities or the pace at which you can do them, or to rest intermittently. You do not have to have symptoms at rest to qualify under this listing.
- ⓒ Heart disease resulting from lung disease (cor pulmonale) that satisfies the criteria in part Ⓐ or Ⓑ.

b. Residual Functional Capacity

If you don't qualify under the listing and have had CHF, it is still possible for you to receive a restricted RFC. Because of the many possibilities for CHF, the SSA does not have exact rules for every cause and severity of CHF. Medical judgment must be applied on a case-by-case basis.

Still, two factors are most important in determining your RFC:

- symptoms related to the heart's decreased ability to pump blood—dyspnea, easy fatigability with exertion, and possibly angina, and
- objective severity—especially measurement of the heart's pumping ability.

It is an unofficial SSA rule that someone who has had one episode of CHF should not receive an RFC higher than for medium work, even if the heart size is normal with treatment. The reasoning is that the underlying disease that caused the heart failure, usually coronary artery disease, is still present and there is no way full heart function can be restored to the ability to do heavy work. If you were treated for heart failure and still have cardiomegaly as shown by a CT ratio of at least 55%, you probably shouldn't receive an RFC for more than light work.

Of course, if treatment or surgery has restored your heart function to normal, then you may not get any RFC restriction. The SSA should not claim, however, that you have no restrictions just because you don't have symptoms at rest. You might be very symptomatic at a certain level of exertion. That is why it is important for the SSA to have good examples of the types and amounts of activities you can carry out before you develop symptoms. For example, there is a significant difference between someone who can walk

several miles briskly and someone who gets shortness of breath walking slowly for a half a block.

In considering what your RFC might be on the basis of the objective evidence, the SSA is going to be most interested in how well the ventricles of your heart perform—especially the left ventricle. The LVEF is important in this regard. While the SSA has no absolute rules, the following guidelines can be useful:

- LVEF in the 40% range—RFC no higher than medium work
- LVEF in the 30% range—RFC no higher than light work
- LVEF in the lower 30% range—RFC no higher than sedentary work.

If you also have a decrease in the right ventricular ejection fraction (RVEF), then your restrictions may be greater.

You don't have to be able to interpret heart studies to find out what your ejection fraction is—it should be on the test report of your cardiac catheterization, echocardiogram or radionuclide study.

Many older claimants with ischemic heart disease also have lung disease related to cigarette smoking. These two separate impairments interact because the action of the heart and lungs affect each other. The SSA should take this interaction into account. For example, suppose you have lung disease that taken alone would restrict you to an RFC for medium work and a heart disorder that taken alone would restrict you to medium work. A final RFC rating for medium work would be a mistake—the combined disorders should result in no higher than an RFC for light work. On the other hand, arthritis and heart disease that would, if considered separately, each warrant an RFC for medium work would probably not produce an overall restriction to an RFC for light work.

If you have a history of congestive heart failure, your RFC should have you avoid exposure to extremes of heat and cold, because such environmental factors put a strain on the cardiovascular system.

2. Listing 104.02: Chronic Heart Failure (Children)

In children, the most common cause of CHF is congenital heart disease, such as abnormal heart valves. Unlike adults, children may have decreased growth as a result of chronic heart failure.

The listing does not require signs of fluid retention such as pulmonary edema, hepatomegaly, ascites or peripheral edema at the time the child applies for disability because potent diuretic drugs can usually remove excess fluid. But

there must be signs of vascular congestion at some point in time—past or present—documented in the child's medical records.

In infants, CHF can manifest itself differently than in older children and adults. In infants, fatigue and exercise intolerance caused by CHF may manifest itself as prolonged feeding time, breathing with effort and sweating. Other manifestations of CHF during infancy may include failure to gain weight or involuntary loss of weight and repeated episodes of pneumonia.

a. Listing Level Severity

Heart failure at some point in time,, as well as a condition described in Ⓐ, Ⓑ, Ⓒ or Ⓓ, below, showing that some significant degree of CHF continues.

Ⓐ Persistent fast heart rate at rest as specified in Table I.

Table I—Tachycardia at Rest

Age	Heart Rate Over (beats per minute)
under 1 year	150
1–3 years	130
4–9 years	120
10–15 years	110
over 15 years	100

An increased rate is the heart's attempt to compensate for its weakened condition. Heart rate taken during physical exertion or emotional upset cannot be used because a heart rate normally increases under those conditions. A doctor must do measurements of heart rate; rates reported by parents cannot be used. Persistent means that all or at least most readings satisfy Table I. One heart rate measurement is not enough—the SSA must have at least two to three readings over a period of at least three months.

Ⓑ Persistent fast breathing at rest as specified in Table II, or markedly decreased exercise tolerance.

Table II—Tachypnea at Rest

Age	Respiratory Rate Over (breaths per minute)
under 1 year	40
1–5 years	35
6–9 years	30
over 9 years	25

The information about the heart rate in part ④ applies here.

Note that part ⑤ can also be satisfied by a markedly decreased exercise tolerance. The SSA applies medical judgment because no exercise test is given. Exercise tolerance must be evaluated in the context of what a child of the same age would normally be capable of doing. As discussed above, exercise intolerance in infants may manifest differently than in older children and adults.

- ③ Recurrent arrhythmias satisfying the criteria in Listing 104.05.
- ④ Growth disturbance with 1, 2 or 3.
 1. Involuntary weight loss (or failure to gain weight at an appropriate rate for age). This involuntary weight loss must result in a fall of at least 15 percentiles on standard growth charts, which lasts at least two months.
 2. Involuntary weight loss (or failure to gain weight at an appropriate rate for age). This involuntary weight loss must result in a fall to below the third percentile on standard growth charts, which lasts at least two months.
 3. Growth impairment as described under the criteria in child growth Listings 100.02 or 100.03. (See Chapter 16.)

3. Listing 4.03: High Blood Pressure (Adults)

In adults, high blood pressure (HBP), or systemic hypertension, is defined as a systolic pressure of 140 mm Hg or greater and a diastolic pressure of 90 mm Hg or greater—that is, 140/90 or more. The systolic pressure is the pressure inside an artery when the heart contracts, and the diastolic is the lower pressure between heart beats. HBP is usually a slow silent killer that does not produce symptoms and damages the internal organs over a number of years. Depending on the type of organ damage, evaluation would be done under the appropriate listings. The heart (this chapter), eyes (Chapter 17), kidneys (Chapter 21) and brain (Chapter 26) are particularly likely to be damaged by uncontrolled hypertension. Even small increases in blood pressure increase the risk of internal organ damage over a period of years, and extremely high pressures present an immediate danger that must be treated as an emergency.

Most HBP can be controlled if the proper treatment is given and received. Unfortunately, millions of people in the U.S. have uncontrolled HBP that will eventually cause them great harm.

a. Listing Level Severity

HPB is evaluated under Listing 4.02 or 4.04, or under the criteria for the affected body system. For example, eye damage would be evaluated under Listings 2.02, 2.03 and 2.04; kidney damage under Listing 6.02; and a stroke under Listing 11.04. (See Chapter 26.)

b. Residual Functional Capacity

HBP is rarely, in and of itself, a reason for the SSA to restrict the exertion you could do on an RFC. Rather, in determining your RFC, the SSA should consider whether organ damage caused by HBP affects your work capacity. For example, a common consequence of HBP is cardiomegaly, and such an enlarged heart could be a basis for restricting exertion. A CT ratio of 55% or more is usually sufficient for the SSA to restrict you to a medium work RFC.

People with only modest hypertension, such as 160/100, may not need any restriction on exertion. A claimant with a hypertensive response to exercise, however, may need a restriction. So might claimants with extremely high blood pressures at rest. For example, a claimant with a persistent systolic BP of about 180 or a diastolic BP of about 110 or higher should probably not receive an RFC higher than medium work. Persistent blood pressures of 210/120 should result in an RFC for sedentary work at most. These are not official SSA policies. Each case must be evaluated individually.

If you develop a dangerous HBP during exercise, as on a cardiac stress test, your RFC should correspond. For example, suppose your blood pressure went to 230/120 at the seven MET level of exercise on a treadmill. Your RFC should be restricted to no higher than light work—an RFC level below seven METS.

4. Listing 104.03: High Blood Pressure (Children)

The age of a child determines what is considered normal blood pressure.

This listing for HBP requires that a child have a BP equal to or exceeding the applicable rate in Table III. In addition, the child's condition must qualify under another listing—106.02 kidney failure (Chapter 21), 111.06 neurological damage (Chapter 26) or 104.02 heart failure (this chapter). A child who qualifies under one of these listings can do so without any reference to blood pressure, making a consideration under Table III unnecessary. In fact, requiring the child to meet both the other listing and the blood pressure rate in Table III could deprive an otherwise deserving child of disability benefits.

It is unknown why the SSA keeps this listing. Obviously, if the child has HBP, use whatever listing is most appropriate to the type of organ damage done and ignore this listing.

a. Listing Level Severity

The child must have HBP with persistently elevated blood pressure equal to or greater than the applicable value in Table III. Additionally, the child's condition must satisfy **A**, **B** or **C**, below.

Table III—Elevated Blood Pressure

Age	Systolic Over (mm Hg)	Diastolic Over (mm Hg)
under 1 month	95	
1 month–2 years	112	74
3–5 years	116	76
6–9 years	122	78
10–12 years	126	82
13–15 years	136	86
16–18 years	142	92

- A** Impaired kidney function, as described in Listing 106.02 (Chapter 21).
- B** Cerebrovascular damage, as described in Listing 111.06 (Chapter 26).
- C** Chronic heart failure as described in Listing 104.02.

5. Listing 4.04: Ischemic Heart Disease (Adults)

Ischemic heart disease deprives the heart muscle of sufficient blood flow. Many people who do not have cardiac ischemia at rest do have it with some level of exertion depending on the severity of the disease. Some people have such severe heart disease that ischemia is present even at rest. Most adults with heart disease are evaluated for disability under this listing.

Most ischemic heart disease is caused by coronary artery disease, but other possible causes include narrowed heart valves and vasospasm of a coronary artery.

Because ischemic heart disease can exist in any degree of severity, how much exertion produces symptoms (fatigue, shortness of breath, angina) is important to disability determination. So is knowing at what level of exertion objective abnormalities appear—such as ST segment depression or elevation on EKGs performed at rest or with exercise. Ischemia can be diagnosed in other ways. One way is with an EKG to show abnormal motion of the heart's walls

during exercise. Another is through radionuclide imaging with thallium and other isotopes to show wall motion abnormalities compatible with ischemia and to detect decreased blood flow to the heart during exercise that improves with rest. Most of the cardiac stress tests requested by the SSA are treadmill stress tests done with EKG and vital sign monitoring. (See discussion of stress testing at the beginning of the chapter.)

To satisfy any part of the listing, you must have established a history of chest pain compatible with angina—you are not required to have angina during the stress test itself. Symptoms during testing, however, can be relevant to the disability determination. Make sure you describe any symptoms you have to the doctor performing the test—both for your safety and your disability claim.

a. Listing Level Severity

Chest pain compatible with angina. Additionally, your condition must satisfy **A**, **B** or **C**, below.

- A** Cardiac exercise stress test (walking on a treadmill or riding a stationary bicycle) with abnormalities appearing at an exertion level equivalent to five METs or less.

Acceptable abnormalities are 1, 2, 3, 4 or 5.

- Horizontal or downsloping ST segment depression at least 1.0 millimeter on the EKG, indicative of cardiac ischemia. (Digitalis, low blood potassium or other factors that can interfere with interpretation of the ST segment must not be present.) The abnormalities must last at least one minute into the recovery period after exercise.
- Upsloping ST depression of at least 2.0 millimeters on the EKG, indicative of cardiac ischemia. (Digitalis, low blood potassium or other factors that can interfere with interpretation of the ST segment must not be present.) The abnormalities must last at least one minute into the recovery period after exercise.
- At least 1.0 millimeter of ST segment elevation during exercise and lasting at least three minutes into the recovery period after exercise.
- Failure to increase the systolic blood pressure by at least 10 mm Hg during exercise, or a decrease in diastolic blood pressure below the usual resting level.
- A documented reversible perfusion defect seen on a thallium radionuclide imaging study.

You are not expected to interpret your own exercise test. The doctor who performed the test will dictate a formal interpretation, however, and you might be able to figure out if you have satisfied part **A**. If a thallium imaging study is done, you will receive an intravenous injection of the thallium isotope before exercise. Your

heart will then be scanned before the stress test and several times after the stress test. Such scanning will add several hours to the test procedure time.

- Ⓑ Decreased heart function, indicated by abnormal wall motions of the heart—akinesis, hypokinesis or dyskinesis. Additionally, the left ventricular ejection fraction (LVEF) must be 30% or less. Any type of study that shows heart wall motion abnormalities in the left ventricle of your heart and a decreased ejection fraction is required. Such evidence could come from cardiac catheterization performed by your treating doctor, echocardiography, radionuclide studies or an MRI of your heart. Part Ⓑ has two other requirements:
- documented history that you are markedly limited in physical activity, as demonstrated by fatigue, palpitations, shortness of breath or angina on ordinary physical activity, even though you may be comfortable at rest, and
 - a decision by an SSA medical consultant that an exercise stress test would be a significant risk to you.
- Ⓒ Coronary artery disease, demonstrated by cardiac catheterization (done by your treating doctor), and an SSA medical consultant doctor decision that an exercise stress test would be a significant risk to you. Additionally, 1 and 2 must be present.
1. Angiographic evidence of coronary artery narrowing as in a, b, c, d or e.
 - a. 50% or more narrowing of a nonbypassed left main coronary artery.
 - b. 70% or more narrowing of another nonbypassed coronary artery.
 - c. 50% or more narrowing involving a long (more than one centimeter) segment of a nonbypassed coronary artery.
 - d. 50% or more narrowing of at least two nonbypassed coronary arteries.
 - e. Total blockage of a blood vessel used as a bypass graft.
 2. Documented history of your marked limitation in physical activity, as demonstrated by fatigue, palpitations, shortness of breath or angina on ordinary physical activity, even though you may be comfortable at rest.

b. Residual Functional Capacity

Significant ischemic heart disease that does not satisfy the listing must have an RFC. Some common RFC levels associated with ischemic heart disease follow. These are not official rules, but are reasonable and generally followed by the SSA.

- Heart attack: medium RFC or lower.
- Heart attack severe enough to also have produced heart failure: light RFC or lower.
- Blockage in one coronary artery between 50–70%: medium RFC or lower.
- Angina and a stress test positive for ischemia at the seven MET level: light RFC or lower.
- Angina and a stress test positive for ischemia at the ten MET level: medium RFC or lower.
- Significant lung disease occurring with heart disease: RFC lower than either alone.
- Prior history of coronary artery bypass surgery: medium RFC or lower, unless higher work capacity is proven with a cardiac exercise test.
- Prior history of percutaneous transluminal coronary angioplasty: medium RFC or lower if remaining lesions block at least 50%.
- Heart attack so severe that it produces a bulging scar in the left ventricle (aneurysm): light RFC or lower.

Sometimes, a claimant suffers from decreased blood flow to the heart but is unaware of it because he doesn't feel any angina. This type of silent ischemia can be associated with weakness and fatigue. Moreover, silent ischemia can cause dangerous arrhythmias that may result in sudden unexpected death. In cases of silent ischemia, the SSA should give an RFC below the exertion level that is thought to cause the ischemia.

6. Listing 4.05: Arrhythmias (Adults)

In adults, arrhythmias—disturbances of the heart's rate or rhythm—are most often caused by ischemic heart disease and other types of cardiomyopathies. In these instances, decreased blood flow to the heart's nerve conduction system, or to areas of heart muscle, interferes with the normal electrical functions in the heart. Also, the resulting scar tissue from a prior heart attack can disrupt electrical impulses spreading through the heart.

One of the most frequent types of arrhythmias seen by the SSA is atrial fibrillation (AF). AF is frequently found in middle-aged and older persons, and alcohol use can trigger this arrhythmia in people who would otherwise not have it. In many instances, AF can be controlled with drugs. If not, a pacemaker can usually achieve control. It would be extremely unusual for atrial arrhythmias of any kind to qualify under this listing, but they can still affect your RFC.

The most dangerous kinds of arrhythmias usually occur as a result of ischemic heart disease or cardiomyopathies, and involve the ventricles of the heart. Ventricular heart beats that occur at the wrong time are called ventricular premature beats (VPBs). Ventricular arrhythmias are the

cause of most cases of sudden cardiac death. Electronic devices known as implantable cardiac defibrillators (ICDs) are sometimes used to help people whose ventricular arrhythmias cannot be controlled with medication or surgery. ICDs are not the same as pacemakers, but deliver powerful electric shocks to terminate dangerous ventricular arrhythmias in people at risk for sudden death. If you have an ICD, the SSA needs all of the information it can get about your arrhythmia—including your symptoms before and after implantation of the ICD and how often it shocks you to correct a ventricular arrhythmia. You also must describe how the shocks affect your ability to carry out your daily activities.

Cardiac arrhythmias are diagnosed on EKGs. Cardiac arrhythmias often come and go, however, rather than being present all of the time. A resting EKG may not show a serious arrhythmia. Prolonged EKG records can be made with a Holter monitor to continuously record your EKG for 12–24 hours while you carry out your normal activities. The SSA sometimes requires Holter monitor tests on claimants to evaluate alleged symptoms that might be caused by an arrhythmia. If you have Holter monitoring, keep a diary of the time, nature and duration of your symptoms. The doctor interpreting the Holter monitor can see if your symptoms match patterns of abnormal heart rhythms appearing on the Holter EKGs. Without keeping such a record, the SSA won't know how any abnormalities on the Holter monitor affect you.

Sometimes cardiac catheterization with electrophysiologic studies (EPS) are needed to find out the exact nature of the arrhythmia regarding its origin in the heart, how it is triggered and how it can be stopped. Small surgical procedures can sometimes be done in conjunction with EPS, such as with lasers, to suppress abnormal nerve conduction pathways. The SSA cannot order an EPS, but if you have had it done, make sure the SSA has the results.

The SSA does not define how often recurrent must be. Medical judgment is applied case by case, depending on your overall ability to function. The more severe the arrhythmia and associated symptoms, the fewer episodes it would take to be disabling.

a. Listing Level Severity

To meet the severity requirements of the listing, you must have recurrent episodes of arrhythmia, not related to reversible causes such as electrolyte imbalance, digitalis or drugs used to treat arrhythmias. The arrhythmia must cause repeated episodes of cardiac syncope or near-syncope despite prescribed treatment. Resting EKGs or Holter monitor-

ing must show the arrhythmia occurring at the same time as the alleged symptoms.

b. Residual Functional Capacity

Although most arrhythmias don't qualify under the listing, many qualify for an RFC. RFCs given for arrhythmias depend on their seriousness, their causes and their response to treatment. AF completely controlled with a drug would probably not rate any restriction nor receive an RFC. But AF that drove the ventricles of the heart too fast and was not controllable with drugs would be a different matter because symptoms and functional limitations would be present.

Ventricular arrhythmias often warrant more restrictions because they are likely to lead to sudden death with exertion. All arrhythmias that are severe enough to produce dizziness or lightheadedness should have restrictions against driving, work at unprotected heights or work around hazardous machinery.

An RFC should take into account that arrhythmias can limit the amount of weight that you can lift or carry because arrhythmias can decrease blood flow to the brain, heart and other parts of the body, resulting in symptoms such as dizziness, loss of balance, weakness and shortness of breath. If you have a history of arrhythmias triggered by lifting or other exertion, your RFC should reflect that. Certainly, if you have an arrhythmia associated with a known amount of exertion on a cardiac stress test, your RFC should be for below that level of exertion. For example, if you had an arrhythmia at seven METs on a treadmill stress test, your RFC should be for no more than light work. If you had an arrhythmia at five or six METs, your RFC should be for sedentary work.

Environmental factors can also affect your RFC. Extremes of heat and cold make people more susceptible to arrhythmias. Psychological stress can cause arrhythmias to worsen—sometimes fatally. And while job stress is subjective depending on the individual, the SSA should make a reasonable judgment. Few people would disagree that air traffic controllers, police officers and prison guards generally have high stress jobs. If stress that affects you personally is not obvious to the SSA, let the SSA know. If your arrhythmia was worsened by your prior work, that fact needs to be documented in your medical records. One strong indicator that your prior work contributed to the severity of your arrhythmia is improvement after you stopped working—any such change should be documented by your treating doctor. Such details are important, because if you can't do your prior work you are one step closer to being found disabled.

7. Listing 104.05: Arrhythmias (Children)

While ischemic heart disease is a frequent cause of arrhythmias in adults, children are most likely to have arrhythmias as a result of congenital heart defects or other diseases affecting the heart. Heart blocks with slow heart rates are a particular problem in children. Some types of heart block are minor and produce few symptoms or limitations. Severe heart blocks, consisting of atrio-ventricular dissociation (A-V dissociation), can be life threatening and require a pacemaker for control.

The SSA does not define how often recurrent must be. Medical judgment must be applied on an individual basis, depending on the child's overall ability to function. The more severe the arrhythmia and associated symptoms, the fewer episodes it would take to be disabling. Because children cannot keep records of their symptoms, a parent or other caregiver must do so. Such records should include what the symptoms are, what the child was doing when the symptoms appeared, the date, the time of day and how long the symptoms lasted.

a. Listing Level Severity

The listing requires the child to have recurrent episodes of arrhythmias, such as persistent or recurrent severe heart block (A-V dissociation), not related to reversible causes such as electrolyte imbalance, digitalis or drugs used to treat arrhythmias. The arrhythmia must cause repeated episodes of cardiac syncope or near-syncope (dizziness, lightheadedness) despite prescribed treatment, including a pacemaker. Resting EKGs or Holter monitoring must show the arrhythmia occurring at the same time as the alleged symptoms.

8. Listing 4.06: Congenital Heart Disease (Adults)

Congenital heart abnormalities involve some kind of malformation like holes that shouldn't be present, absence of a part of the heart or misplacement of the aorta or large veins (vena cavae) in relation to the heart. A ventricular septal defect (VSD) is the most common. Atrial septal defect (ASD) also occurs with some frequency. Most congenital heart disease is seen in children, but many now survive into adulthood thanks to advanced surgical procedures. Although VSDs and ASDs alone can be easy to repair with a patch covering the abnormal hole, congenital heart diseases like tetralogy of Fallot can involve multiple defects.

An important distinction in types of congenital heart disease is whether the disease is cyanotic or acyanotic. Cyanotic congenital heart disease is associated with difficulty oxy-

genating blood because of shunting of blood flow away from the lungs. Examples of cyanotic heart disease include failure to develop heart valves (tricuspid valve atresia, aortic valve atresia, pulmonary valve atresia), tetralogy of Fallot, transposition of the great arteries, truncus arteriosus and total anomalous pulmonary venous connection. Examples of acyanotic heart disease are ventricular septal defects, atrial septal defects and patent ductus arteriosus. The difference between cyanotic and acyanotic heart disease is not absolute. People with cyanotic heart disease may not always show the bluish skin discoloration of cyanosis, especially at rest. Similarly, someone with severe acyanotic heart disease may develop cyanosis, particularly with exercise.

a. Listing Level Severity

You must have symptomatic congenital heart disease (cyanotic or acyanotic) documented by appropriate imaging techniques such as cardiac catheterization, echocardiography or radionuclide scans. Additionally, you must have **A**, **B**, **C**, **D** or **E**, below.

- A** Cyanosis at rest. Additionally, you must satisfy 1 or 2.
 1. Hematocrit of 55% or greater.
 2. Arterial oxygen saturation (SaO_2) of less than 90% in room air or a resting arterial oxygen pressure (PaO_2) of 60 mm Hg or less.
- B** Intermittent right to left shunting of blood within the heart resulting in cyanosis on exertion (such as Eisenmenger's physiology) and with an arterial oxygen pressure (PaO_2) of 60 mm Hg or less at a workload of five METs or less.
- C** Chronic heart failure with evidence of abnormal function of the heart's ventricle, as described in Listing 4.02.
- D** Recurrent arrhythmias as described in Listing 4.05.
- E** Secondary pulmonary vascular obstructive disease (PVOD) with an average pulmonary arterial blood pressure elevated to at least 70% of the average systemic arterial pressure—that is, congenital heart disease with abnormally increased blood flow through the lungs. The abnormal flow damages the lungs so they increasingly resist the flow. PVOD causes blood pressure to go up in the pulmonary arteries (pulmonary hypertension).

This listing is satisfied if the average pressure inside your pulmonary arteries is 70% or more of your average systemic arterial blood pressure. The pressures are measured during cardiac catheterization, which must have been done by your treating doctor. Here's how it works. Let's say your catheterization report gives your average systemic arterial pressure as 85 mm Hg. $70\% \text{ of } 85 = 59.5$. Therefore, if you had an average pulmonary artery pressure of about 59–60 mm Hg or higher you would

qualify under the listing. Average pulmonary artery pressure is normally only about 15 mm Hg. What if your average systemic pressure was 92 mm Hg and your average pulmonary artery pressure was elevated at 40 mm Hg? In that case, 40 divided by 92 is 43%—a value that is abnormal but not high enough for the 70% requirement of the listing.

b. Residual Functional Capacity

Congenital heart disease is too complex for the SSA to have specific RFC guidelines. Appropriate medical judgment must be applied to individual cases, taking into account the exact nature of your congenital heart disease, your treatment, and your current symptoms. If your condition is close in severity to the requirements of the listing, you should not receive more than a sedentary RFC. The discussion of RFC under Listing 4.02 regarding congestive heart failure may be appropriate here. If you have arrhythmias, see also the discussion of RFC under Listing 4.05.

9. Listing 104.06: Congenital Heart Disease (Children)

The introduction to Listing 4.06 applies here.

a. Listing Level Severity

The child's condition must satisfy (A), (B), (C), (D), (E), (F), (G) or (H).

- (A) Cyanotic heart disease, with persistent hypoxemia. Additionally, the child's condition must satisfy 1, 2, 3 or 4.
 1. Hematocrit of 55% or greater on two or more evaluations within a three-month period.
 2. Arterial oxygen saturation (SaO_2) of less than 90% in room air or a resting arterial oxygen pressure (PaO_2) of 60 Torr (mm Hg) or less.
 3. Hypercyanotic spells, syncope, characteristic squatting or other incapacitating symptoms directly related to documented cyanotic heart disease. These symptoms are associated with tetralogy of Fallot. Children with tetralogy of Fallot tend to squat to relieve dyspnea brought on by activity. Any severe symptoms, however, can qualify if they are caused by some type of cyanotic heart disease.
 4. Exercise intolerance with increased hypoxemia on exertion. Exercise must be limited or produce distress and be accompanied by a worsening of oxygenation. The degree of worsening is not specified; any amount would be sufficient. Observations of the child during exertion, along with either a fall in arterial oxygen saturation or oxygen pressure should be

sufficient to establish hypoxemia. Oxygen saturation is easier to measure because a sensor on the child's finger can provide a readout, while oxygen pressure requires the child's presence in a hospital or clinic.

- (C) Chronic heart failure with evidence of abnormal function of the heart's ventricle, as described in Listing 104.02.
- (D) Recurrent arrhythmias as described in Listing 104.05.
- (E) Secondary pulmonary vascular obstructive disease with an average pulmonary arterial blood pressure elevated to at least 70% of the average systemic arterial pressure. See discussion of part (E) under adult Listing 4.06. The criteria are more lenient in disorders that affect the lung's arteries directly, such as primary pulmonary hypertension, emphysema, chronic bronchitis, cystic fibrosis and certain connective tissue diseases. In these instances, the average pulmonary artery only needs to be 50% of the average systemic blood pressure. For example, if the child's average pulmonary artery pressure were 40 mm Hg and the average systemic pressure was 80 mm Hg, the child should be granted benefits.
- (F) Congenital valvular defects as described in Listing 104.07.
- (G) Symptomatic acyanotic heart disease with ventricular dysfunction that results in significant restriction of age-appropriate daily activities or inability to complete age-appropriate tasks. This covers children whose hearts have difficulty pumping enough blood. Weakness, easy fatigability and shortness of breath can limit the child's ability to carry out normal daily activities. Similarly, symptoms may prevent a child from finishing tasks.
- (H) Growth failure as described under the criteria in child growth impairment Listings 100.02 or 100.03. (See Chapter 16.)
- (H) Infants under 12 months of age at the time of filing for benefits who have a life-threatening congenital heart disease that will require surgery, or who have had surgical treatment in the first year of life. Such infants are considered to be under a disability until they are either one year of age or until 12 months after surgery, whichever is later. Examples of life-threatening congenital heart disease are hypoplastic left heart syndrome, critical aortic valve stenosis, complete A-V canal defects, transposition of the great arteries, tetralogy of Fallot and atresia of the pulmonary valve. Critical coarctation of the aorta could also fall in this category.

10. Listing 4.07: Heart Valve Disease (Adults)

The four heart valves inside the heart are the aortic, pulmonary, mitral and tricuspid. Valves have leaflets that open in one direction only when the heart contracts to squeeze

blood through them. When the heart relaxes between beats, the valve leaflets close to stop blood from flowing back in the direction from which it was pumped. Stenotic valves resist blood flow through their narrowed openings. Valves that are insufficient do not close firmly. In congenital heart disease, valves may be missing or malformed.

Degenerative diseases or infection can damage heart valves. Valve disease may have serious sudden effects on the heart's function or may slowly progress over many years. For example, aortic stenosis may be present for decades, slowly getting worse; individuals are often over 70 years of age before the symptoms become severe. On the other hand, a severely narrowed aortic valve at birth would require immediate surgical repair. Sudden severe mitral insufficiency can precipitate acute heart failure. Most cases of mitral stenosis result from heart valve calcification and damage from rheumatic fever as a child. People with a disorder called Ebstein's anomaly of the tricuspid valve often die from heart failure or arrhythmias of the heart by their mid-20s. All valve disorder cases are not the same—the causes, treatment and prognoses are considerably different.

Replacement of defective valves with prosthetic valves is commonplace. Replacement valves can be mechanical or derived from animals. Mechanical valves require long-term anticoagulation to prevent the formation of blood clots within the heart, so individuals with these valves are at increased risk of bleeding. Pig valve replacements (porcine valves) do not require long-term anticoagulation. Possible problems with prosthetic valves in general include infection, coming unseated from the heart and breaking.

After valve surgery, a doctor needs three months to evaluate the results. Surgery doesn't necessarily involve an artificial valve. A diseased valve may be surgically repaired (valvuloplasty), such as when a balloon-tipped catheter is inserted into a stenosed valve and inflated to increase the size of the valve (balloon valvuloplasty). A stenosed valve might be widened by an incision into the valve (valvotomy). A loose valve can sometimes be tightened down with an annuloplasty.

Valvular heart disease must be documented by appropriate imaging techniques, such as echocardiography, MRI or x-rays obtained at cardiac catheterization. The possible complications of valve disorders are heart failure (Listing 4.02), ischemia (Listing 4.04), arrhythmias (Listing 4.05) and strokes (Listing 11.04 in Chapter 26). The risk of stroke arises from blood clots formed in the heart from abnormal valve function which can then be pumped into the arteries of the brain.

a. Listing Level Severity

You must have valvular heart disease, as documented by appropriate imaging techniques. The impairment is evaluated under the criteria of Listings 4.02, 4.04, 4.05 or 11.04 (See Chapter 26) as appropriate.

b. Residual Functional Capacity

In the absence of evidence of normal exercise ability, the SSA will generally accept an RFC restricted to medium work if you have a prosthetic heart valve. If you have two separate prosthetic heart valves, you might be restricted to no more than light work. If you have other heart problems that did not improve with valve replacement, your RFC could be even lower. If you are taking anticoagulant drugs because of having a mechanical heart valve replacement, you are at increased risk of bleeding from cuts or trauma—your RFC might limit you from handling heavy objects. The SSA has no definite rules and medical judgment should be used case by case, considering all of the objective evidence as well as your symptoms.

11. Listing 104.07: Heart Valve Disease (Children)

The comments under Listing 4.07 apply here.

a. Listing Level Severity

The child's condition must satisfy part ④ or ⑤, below.

④ Valvular heart disease as documented by appropriate imaging techniques. The impairment is evaluated under the criteria of Listings 104.02, 104.05, 111.06 or the adult listing 11.04 as appropriate (see Chapter 26).

⑤ Critical (life-threatening) aortic stenosis in a newborn.

12. Listing 4.08: Cardiomyopathies (Adults)

The prognosis for cardiomyopathies depends to a large extent on how well the underlying cause can be treated. For example, ischemic heart disease may be improved considerably by restoration of blood supply to the heart muscle, as with coronary artery bypass grafting. Scarred heart muscle as a result of heart attacks, however, cannot be restored to function. Alcoholic cardiomyopathy is frequently seen by the SSA and may be reversible to some degree by abstention from alcohol. Viral infections of the heart sometimes resolve, but can lead to heart failure and death. Connective tissue diseases like progressive systemic sclerosis and systemic lupus can cause permanent heart damage. Genetic disorders of heart muscle, such as hyper-

trophic cardiomyopathy, has no cure. These are only a few examples of some common types of cardiomyopathy.

Cardiomyopathy must be documented by appropriate imaging techniques such as echocardiography, MRI or x-rays obtained at cardiac catheterization. The possible abnormalities associated with cardiomyopathies are heart failure (Listing 4.02), ischemia (Listing 4.04), arrhythmias (Listing 4.05) and strokes (Listing 11.04 in Chapter 26).

a. Listing Level Severity

You must have cardiomyopathy documented by appropriate imaging techniques. The impairment is evaluated under the criteria of Listings 104.02, 104.04, 4.05 or 11.04 (see Chapter 26) as appropriate.

b. Residual Functional Capacity

The discussion of RFC under Listing 4.02 regarding congestive heart failure applies here. If you have arrhythmias, the discussion of RFC under Listing 4.05 would also apply.

13. Listing 104.08: Cardiomyopathies (Children)

The comments under Listing 4.08 apply here. An additional difficulty in evaluating this condition in children is that heart size depends on age. The required left ventricular ejection fraction of 50% or less is not extremely low, but is abnormal enough to indicate cardiomyopathy. Similarly, a significant enlargement of the inside of the left ventricle—the left ventricular end diastolic diameter (LVEDD)—is to be expected if the cardiomyopathy is more than slight in severity. Marked enlargement is not required. The LVEDD can easily be measured by echocardiography and other imaging techniques.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have cardiomyopathies, documented by appropriate imaging techniques. The child must have a left ventricular ejection fraction of 50% or less and significant enlargement of the left ventricular chamber. Then the condition is evaluated under the criteria of Listings 104.02, 104.05 or 11.06 (see Chapter 26).

14. Listing 4.09: Heart Transplants (Adults)

Heart transplants require close monitoring for immune rejection and other possible complications, particularly during the first year after surgery. For example, the coronary arteries of transplanted hearts are extremely prone to development of severe coronary artery disease.

a. Listing Level Severity

An adult is considered disabled for one year following surgery. After that, residual impairment is evaluated under whatever heart listings are appropriate.

b. Residual Functional Capacity

RFCs don't apply because anyone with heart transplant surgery is entitled to benefits for the year after surgery. After that time, each case is evaluated on an individual basis. Heart transplant recipients usually remain in benefit status, however.

15. Listing 104.09: Heart Transplants (Children)

The comments under Listing 4.09 apply here.

a. Listing Level Severity

A child is considered disabled for one year following heart transplant surgery. After that, residual impairment is evaluated under whatever heart listings are appropriate.

16. Listing 4.10: Aneurysms of the Aorta or Major Branches (Adults)

Aneurysms can rupture and result in a quick death from internal bleeding. This is particularly true for aortic aneurysms—the aorta is the largest artery in the body. The listing also permits allowance based on aneurysms of large arteries that branch from the aorta, such as the renal artery to the kidney.

Aneurysms may be associated with entry of blood into the wall of the artery, especially in aortic aneurysms, so that the layers of the artery are split in a lengthwise direction. This process of dissection is dangerous because it might lead to rupture of the aneurysm.

Aortic aneurysms may be short or involve the entire length of the aorta, and therefore vary greatly in severity and possible complications. If an aortic aneurysm extends to the heart itself, it can affect the coronary arteries and function of the aortic valve, resulting in heart failure. If an aortic aneurysm extends to the area where the renal arteries come off of the aorta to the kidneys, kidney failure can result from inadequate blood flow. Large aortic aneurysms may interfere with the blood supply to the spinal cord and produce neurological deficits such as paralysis which may also be a complication of extensive surgery for such aneurysms.

Aortic aneurysms involving the part of the aorta in the chest (thoracic aortic aneurysms) are generally more dangerous and difficult to surgically repair than abdominal aortic aneurysms. In fact, newer surgical techniques allow the

repair of some abdominal aneurysms merely by the insertion of a catheter rather than requiring a large abdominal incision.

Aortic aneurysms have a genetic predisposition, but smoking, atherosclerosis and uncontrolled high blood pressure may contribute. Aneurysms may be caused by trauma, infections (such as syphilis) and specific disorders like Marfan's syndrome. Regardless of the cause, the basic aim is the same: prevent rupture. Rupture of an aortic aneurysm is a catastrophic event with high mortality. When aortic aneurysms reach about two inches in diameter (five centimeters), the risk of rupture warrants surgery. With other complications, earlier surgery may be required. Aneurysms tend to enlarge over time; they never become smaller. The rate at which aneurysms enlarge is highly variable among individuals. Some people have aortic aneurysms that enlarge so slowly they avoid surgery for years or even die of other causes before surgery is needed. Others have rapidly enlarging aneurysms that must be treated aggressively.

The easiest way to follow the size of many aneurysms is with ultrasonic imaging, because the use of high-frequency sound bounced off of internal organs to make pictures is safe, painless and quick. Other imaging techniques are also possible, such as MRI and x-ray angiography.

Allowances under this listing are rare because afflicted individuals who could satisfy the listing usually have suffered a fatal rupture or are improved with surgical intervention. Claimants with aneurysms of lesser severity or who have received surgery, however, may have RFCs that significantly affect their ability to work.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have an aneurysm of the aorta or major branches, due to any cause, demonstrated by appropriate imaging techniques. Additionally, you must satisfy **A**, **B**, **C** or **D**, below.

- A** Acute or chronic dissection not controlled by prescribed medical or surgical treatment.
- B** Chronic heart failure as described under Listing 4.02.
- C** Kidney (renal) failure as described under Listing 6.02 (Chapter 21).
- D** Neurological complications as described under Listing 11.04 (Chapter 26).

b. Residual Functional Capacity

It is difficult to say how much weight a person with an aneurysm can safely lift and carry before and after aneurysm surgery because no doctor is going to carry out such a

study. Nevertheless, reasonable medical judgment can be applied on a case-by-case basis.

An unrepaired aortic aneurysm that is large enough to present a danger of rupturing should receive an RFC for no higher than light work. Extremely small aneurysms may warrant no restrictions. Size and location are important: involvement of the aortic root where the aorta attaches to the left ventricle of the heart is particularly dangerous, as are long aneurysms extending from the chest down into the abdomen. Such long aneurysms could easily result in restrictions to sedentary work before surgery even if they produce no symptoms. In fact, unless they are dissecting and about to rupture, aneurysms don't tend to cause symptoms. During dissection, severe chest and back pain should be treated as a medical emergency. If you have high blood pressure, controlling it will decrease the chance of rupture. If your blood pressure is not under good control, the SSA should lower your RFC appropriately.

Extensive surgical repair of a large, complicated aneurysm involving the heart or other organs may warrant restrictions to no higher than a medium or light RFC, even if the surgery was successful. On the other hand, lower abdominal aortic aneurysms that have been surgically repaired without complications often leave no significant impairment, and require no restrictions.

17. Listing 4.11: Chronic Venous Insufficiency (Adults)

Chronic venous insufficiency is a serious and common disorder in adults. Inflammation, trauma and hereditary predisposition may be associated with the development of venous insufficiency.

Veins are very delicate—they have thin walls with essentially no muscle. Although they do not become blocked with fatty deposits, like arteries, they can become damaged through infection or other diseases. While the heart forces blood through the arteries, the movement of blood upward through the leg veins is helped greatly by the pressure applied by surrounding muscles. Veins have one-way valves that allow blood to move upward, but not downward.

The legs have two venous systems—superficial and deep. The superficial system involves the veins that can be seen running under the surface of the skin. Damage to these veins can produce superficial varicosities most familiar to people. Damage to the deep system of veins can lead to severe impairment. The deep system of veins cannot be seen on physical examination. Imaging techniques, such as Doppler ultrasound, can detect deep venous thrombosis (DVT) as can direct x-ray visualization of veins by venography. Also, an

MRI can be used to see the deep veins. DVT can not only block venous blood flow and lead to venous insufficiency, but also carries the risk of pulmonary thromboembolism. Anticoagulation can prevent blood clots from forming and avoid this complication.

Although not stated by the listing, only one leg need be involved to allow a disability finding.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have chronic venous insufficiency of a lower extremity, with incompetency or obstruction of the deep venous system. Additionally you must satisfy part ① or ②, below.

- ① Extensive brawny edema. This would involve most of the leg and foot, at least below the knee.
- ② Superficial varicosities, stasis dermatitis and recurrent or persistent ulceration which has not healed following at least three months of prescribed medical or surgical therapy.

b. Residual Functional Capacity

If your venous insufficiency is not severe enough to qualify under the listing, you could still be highly restricted on the basis of an RFC. The SSA should consider two key points.

1. **How long you can stand.** In all but the mildest cases of venous insufficiency, prolonged standing day after day will lead to aching discomfort in the legs and problems with increased swelling. Thromboembolic stockings are routinely worn by patients with venous insufficiency to help prevent swelling in the legs; these elastic stockings are very helpful in providing compression to keep fluid build-up down. But such stockings cannot permit standing six to eight hours daily, except in very modest cases of venous insufficiency. Inability to stand for prolonged periods will automatically reduce your RFC to sedentary work. People with venous insufficiency should also avoid prolonged continuous sitting, but this problem can be solved by standing and moving around every couple of hours. The SSA should probably not say you can do jobs that require continuous sitting more than two hours at a time.
2. **Anticoagulation.** If you are taking anticoagulant drugs, you are at increased risk of bleeding from cuts or trauma. It is questionable whether handling heavy objects is safe, and restriction to no higher than medium work on your RFC might be appropriate. The SSA has no definite rules, and medical judgment must be used case by case, considering all evidence and your symptoms. In medical-vocational consideration of jobs you might be able to

perform based on your RFC, jobs requiring close proximity to moving blades or other equipment that could cause significant trauma should also be avoided.

18. Listing 4.12: Peripheral Arterial Disease (Adults)

Much peripheral arterial disease is caused by the same type of atherosclerotic process that results in coronary artery disease—fatty plaques that block arterial blood flow to skin, muscles and other tissues. This ischemia of muscles results in the pain of intermittent claudication. If you have intermittent claudication, take careful note of where the pain is, what it feels like, what usually causes it, what relieves the pain and how long it lasts. The SSA will ask for such a description—from your treating doctor's records or a consultative examination. You can save a lot of time if you make sure your doctor has written down your symptoms in detail. The SSA will not simply accept a diagnosis of intermittent claudication from your treating doctor.

On physical examination, abnormalities suggesting peripheral arterial disease are hair loss on the feet and toes, cold feet, thickening of the toenails and difficulty feeling the pulses in the feet. Extremely advanced cases can include ulceration and even gangrene of feet and toes. Keep in mind, however, that failure to feel pulses in the feet or ankles can mean a number of things. Factors like obesity or swelling in the feet can make feeling pulses impossible. In some people, pulses are just difficult to feel.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have peripheral arterial disease and you must satisfy ① or ②.

- ① Intermittent claudication, and also inability to see the common femoral or deep femoral artery using arteriography. Blockage of one of these arteries in only one extremity is required. The most accurate method of diagnosing peripheral arterial disease involves angiography to obtain x-rays showing the exact location and degree of blockage of arteries, if any. Because angiography is invasive, the SSA will not ask you to undergo such testing. If your treating doctor has performed such a procedure, make sure the SSA has the results. The common and deep femoral arteries are major arteries in the thigh and branch into other arteries supplying the leg with blood. Failure to visualize either of these arteries means that a blockage of blood flow prevents x-ray images being made of the artery past the blockage—it has no blood flow.

Ⓑ Intermittent claudication with marked impairment of peripheral arterial circulation as determined by Doppler studies. Because Doppler ultrasound is a harmless, non-invasive way of measuring blood flow to your legs and feet, the SSA can order such test if you have symptoms that might be intermittent claudication. Note the Doppler test used for this listing is not the same as Doppler echocardiography used to study the heart, although they use the same basic principles. Results of Doppler studies must show 1 or 2.

1. Resting ankle/brachial systolic blood pressure ratio of less than 0.50. The systolic ankle blood pressure is measured in the posterior tibial artery just behind the inner ankle bone. If you gently place a fingertip there, you can probably feel the artery pulsating—it is one of your “peripheral pulses” that doctors should always check on any complete physical examination. Normally, this ankle artery pressure is higher than that in the arm, so the Doppler index should be higher than 1. For example, suppose the doctor puts the Doppler transducer over your ankle artery and measures the systolic pressure as 100 mm Hg. Then the pressure is measured in the brachial artery of your arm at 80 mm Hg. Such a result is normal, with an ankle/brachial (A/B) ratio, or Doppler index, of $100/80 = 1.25$. But say your ankle pressure is 50 mm Hg, while that in your arm is 100 mm Hg. This would result in a DI of $50/100 = 0.5$, which indicates a very severe restriction of blood flow to the leg involved and would be at listing-level severity.
2. Decrease in systolic blood pressure at the ankle of 50% or more of the value at the ankle before exercise, and requiring ten minutes or more to return to pre-exercise level. This exercise is not as strenuous as cardiac stress testing, but the same cautions apply—see the discussion of cardiac stress testing under “General Information” at the beginning of this chapter. Your ankle systolic pressures are measured before exercise, then right after exercise and several more times. If exercise makes the pressure in either ankle artery drop to half or less of the pre-exercise value then the listing is satisfied, provided it takes at least ten minutes to return to its pre-exercise level. For example, if you had a pre-exercise systolic pressure of 70 mm Hg in your right ankle artery, it dropped to 35 mm Hg with exercise, and then took 15 minutes to return to 70 mm Hg, you would qualify.

The exercise involves walking on a treadmill at two miles per hour and 10% to 12% grade for five minutes. Even though you are not being tested for heart disease,

your EKG should still be monitored to detect possible arrhythmias or ischemia associated with exercise, because a significant number of people with peripheral arterial disease also have coronary artery disease.

Some disorders, like diabetes, typically cause damage to arteries smaller than those measured by Doppler in part Ⓑ. If you have a disorder which affects the smaller vessels, the SSA should not rely on Doppler pressure measurements when they are not reliable.

b. Residual Functional Capacity

With aortofemoral bypass grafting, many people with large artery involvement can have blood flow restored to their legs. If the surgery is completely successful, there is no reason for significant restrictions. When Doppler indexes in both ankles are 0.80 or higher, whether or not surgery has been done, there is usually an absence of significant impairment. Because a Doppler index of 0.5 satisfies the listing and 0.8 or higher is not severe, values in between could be divided up to represent other RFC levels. For example, a resting Doppler index in the 0.7–0.8 range might receive an RFC for medium work, 0.6–0.7 for light work and 0.5–0.6 sedentary work. The SSA has no such rigid rules, but this approach provides a framework that can be modified based on your individual medical condition, as well as symptoms.

The SSA may ask you to undergo exercise testing. The advantage is that you can be observed and ankle blood pressure readings made in relation to a known amount of exercise. A reasonable RFC can then be determined, based on how close you are to listing-level severity. For example, if your ankle systolic pressure fell to 60% of your pre-exercise reading, but returned to normal in eight minutes instead of ten minutes you probably couldn't do more than sedentary work. Medical judgment must be applied on a case-by-case basis, but remember, if you can't stand or walk six to eight hours daily without intermittent claudication, you should not receive an RFC for over sedentary work. Intermittent claudication would also prevent more than occasional use of leg controls, especially if much force has to be used.

19. Listing 104.13: Rheumatic Fever (Children)

Rheumatic fever is a collection of abnormalities associated with what are called Group A streptococcal bacterial infections. No tests definitely diagnose rheumatic fever, but a group of findings make the diagnosis likely. The diagnosis of rheumatic fever is usually done with what are called the revised Jones Criteria. The SSA specifically mentions such criteria in its regulations.

Some of the major findings in rheumatic fever are carditis, migratory polyarthritis, erythema marginatum, chorea and subcutaneous nodules. The rheumatic fever usually begins one to three weeks after the streptococcal infection. Minor diagnostic criteria consisting of fever, arthralgia, elevated erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), a prolonged P-R interval and a previous episode of rheumatic fever can help. After establishing a prior Group A streptococcal infection, two major criteria or one major and two minor criteria make the diagnosis of rheumatic fever likely. If the child's medical records don't contain abnormalities that fit the Jones Criteria, it is unlikely that the SSA will accept the diagnosis of rheumatic fever.

It is rare for any child to be given an allowance under this listing.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listings, the child must have chronic rheumatic fever with rheumatic heart disease. The child will be considered under a disability for 18 months from the established onset of the impairment, if Ⓐ, Ⓑ or Ⓒ is present.

- Ⓐ Persistence of rheumatic fever activity for six months or more, manifested by significant murmurs, cardiomegaly, ventricular dysfunction and other abnormal laboratory findings such as an elevated sedimentation rate or EKG abnormalities. This listing establishes that active rheumatic fever significantly affects the child's heart function. Ventricular dysfunction is indicated by marked enlargement of the left ventricular cavity above established normal values for the child's age, or markedly reduced ejection fraction or shortening fraction by an appropriate imaging technique such as echocardiography. The ventricular enlargement can easily be detected using echocardiography to measure the left ventricular end diastolic diameter (LVEDD).
- Ⓑ Evidence of chronic heart failure, as described under Listing 104.02.
- Ⓒ Recurrent arrhythmias, as described under Listing 104.05.

20. Listing 104.14: Hyperlipidemia (Children)

This listing requires a homozygous form of inherited hyperlipidemia, meaning the child has received abnormal genes for the production of high blood fats from both parents. The disorder required by the listing is called Type II homozygous familial hyperlipidemia, and is associated with extremely high levels of blood cholesterol. Hypercholesterolemia is so

severe that children with this disorder may have coronary artery disease from fatty blockages by age ten and be dead before age 30.

There is a heterozygous form of the disorder, which means the child inherited abnormal genes from only one parent. Such children do not have as severe a disease; the listing applies only to the homozygous form.

Few children are granted benefits under this listing because the disorder is extremely rare, occurring in about one in a million children.

a. Listing Level Severity



In the listing that follows, the SSA states that the concentration of blood cholesterol must be "500 mg/ml or greater" (500 milligrams of cholesterol per milliliter of blood serum), which is impossibly high. In actuality, children with the disorder in this listing have blood cholesterol levels of 500–1,000 mg/100 ml. The listing has the required value 50 to 100 times too high, probably because of a typographical error that the SSA has never fixed. The "500 mg/ml" should instead be read as 500 mg/100 ml. On a laboratory report this would be the same as 500 mg/dl or 500 mg%.

Documented Type II homozygous hyperlipidemia with repeated plasma cholesterol levels of 500 mg/ml or greater.

The child must also satisfy Ⓐ, Ⓑ, Ⓒ or Ⓓ.

- Ⓐ Cardiac ischemia as described in adult Listings 4.04B or 4.04C.
- Ⓑ Significant aortic stenosis documented by Doppler echocardiography or cardiac catheterization. Significant means more than mild narrowing of the aortic valve compared to the size expected for the child's age. If the child's treating doctor has done a cardiac catheterization, it should be made available to the SSA. Doppler echocardiography can determine heart valve size by the velocity of blood through the valve; it is a harmless, painless, noninvasive test. The more narrowed the aortic valve, the faster the blood will move through it.
- Ⓒ Major disruption of normal life activities by repeated hospitalizations for plasmapheresis or other prescribed therapies, including liver transplant.
- Ⓓ Recurrent pancreatitis complicating hyperlipidemia. The SSA does not define recurrent. Medical judgment must be applied on an individual basis, depending on how much the episodes affect the child's ability to function as a normal child. The more severe the pancreatitis and associated symptoms, the fewer episodes it would take to be disabling.

21. Listing 104.15: Kawasaki Syndrome (Children)

The Kawasaki syndrome is a disorder of unknown cause, usually occurring in children under five years of age. This disorder causes vasculitis of the coronary arteries. It is possible for children to have heart attacks with Kawasaki syndrome resulting from the formation of blood clots in coronary arteries—something that usually happens only to adults. Aneurysms of coronary arteries may also be present, as well as myocarditis.

The disorder may involve organs other than the heart. For example, the child may have meningitis, pericarditis, lymphadenopathy, iridocyclitis, arthralgia, skin rashes, abdominal pain and involvement of the nervous system.

There are no diagnostic tests for Kawasaki syndrome, but imaging of the heart as with two-dimensional (2-D) echocardiography and nonspecific tests for inflammation such as the erythrocyte sedimentation rate (ESR) can be helpful.

The worst manifestations of the Kawasaki syndrome involve the heart and that is the concern of this listing. Other manifestations should be considered under the appropriate listing.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listings, the child must have Kawasaki syndrome that satisfies the requirements of Ⓐ or Ⓑ.

- Ⓐ Major coronary artery aneurysms—that is, the left main, circumflex, left anterior descending or right coronary arteries. This kind of information would be obtained from cardiac catheterization, the results of which would have to be requested from the treating doctor or hospital where the catheterization was performed.
- Ⓑ Chronic heart failure, as described in Listing 104.02. ■

Chapter 20

Digestive System Diseases

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Abdominal distention. Enlargement of the abdomen, as with ascites or intestinal gas.

Abdominal paracentesis. Puncture of the abdominal wall for the purpose of obtaining a sample of ascites for diagnostic purposes or to drain ascitic fluid.

Abscess. Infection occurring as a localized collection of pus.

Albumin. Protein made only in the liver; accounts for half of the protein in the blood stream. Serves as a carrier for numerous bodily substances, as well as some drugs. Normal albumin levels are about 3.5–5.0 grams/deciliter (gm/dl or gm/100 ml).

Anemia. Low red blood cell count usually determined by a decrease in the hematocrit.

Angiography. Any technique to produce images of arteries, such as by x-rays or MRI scans. Usually involves injection of contrast material into the artery to make it visible. Also known as *arteriography*.

Anorexia. Loss of appetite. Anorexia is a frequent problem in chronic diseases, including cancer.

Ascites. Abnormal accumulation of fluid in the abdomen. A frequent cause of ascites is liver failure associated with alcoholism.

Atresia. Failure of an organ or tissue to develop during embryonic life. For example, failure of the aortic valve of the heart to develop is known as aortic valve atresia.

Barium enema. X-ray study of the large intestine following an enema of barium contrast material.

Barium swallow. X-ray study of the esophagus taken after swallowing barium contrast material.

Bile. Greenish-brown liquid excreted by the liver. It is stored in the gallbladder and flows down ducts to enter the duodenum during the digestion of food. Bile is important in facilitating the digestion of fats.

Biliary cirrhosis. Liver damage resulting from disorders of the bile duct system.

Bilirubin. Brownish-yellow breakdown product of the hemoglobin in red blood cells. Bilirubin is made in the liver and excreted in the bile. Normal blood total bilirubin is about 0.3–1.0 milligrams/deciliter (mg/dl or mg/100 ml).

Biopsy. The process of taking a sample of tissue for detailed analysis of various kinds. Biopsy specimens are observed grossly with the eyes, microscopically with a variety of possible tissue stains and in some cases may involve specific chemical and DNA analysis.

Bowel. Intestine.

Cardiac cirrhosis. Liver damage caused by congestive heart failure.

Carotene. Any of the four forms of colored substances naturally found in food. These fat-soluble carotenes will be at a normal level in the blood with adequate nutrition and absorption from the intestine.

Cicatrix. A scar. As an example of usage, a narrowing of the esophagus caused by scarring is said to be a *cicatricial stenosis* of the esophagus.

Cirrhosis. Form of advanced liver disease characterized by bands of fibrous degeneration that may be thought of as a type of scarring inside the liver.

Colectomy. Removal of a part of the colon. A *total colectomy* means removal of the entire colon.

Colon. The large intestine.

Colostomy. Surgically placed opening from the colon through the abdominal wall to the outside of the body.

Common bile duct. Final part of the bile duct system (biliary tree) that empties bile into the small intestine.

Computerized axial tomography (CAT Scan, CT Scan). Multiple x-ray “slices” analyzed by a computer and made into detailed images.

Crohn’s disease. See *regional enteritis*.

Digestion. Process of changing food into chemicals that can be absorbed and used by the body.

Digestive tract. Route food moves through the mouth, esophagus, stomach and intestines. Also known as the *alimentary tract*.

Dilation. Enlargement of an opening or tubular structure such as intestine or artery. Also known as *dilatation*.

Distention. See *abdominal distention*.

Dumping syndrome. Symptoms (sweating, abdominal fullness and distention, rumbling sound from the movement of intestinal gas, nausea, sleepiness, diarrhea, syncope, chest palpitations or fatigue) occurring after eating a meal. Only a few symptoms are usually present. Dumping syndrome is associated with the rapid emptying of stomach contents into the small intestine, especially if a person has had a partial gastrectomy with anastomosis (surgically placed openings between organs or vessels) of the jejunum of the small intestine to the stomach.

Duodenum. First part of the small intestine starting from the stomach.

Endoscopic retrograde cholangiopancreatography (ERCP). Procedure involving insertion of a fiberoptic endoscope through the mouth, esophagus, stomach and into the first part of the small intestine (duodenum). The pancreatic and bile ducts can be examined and x-rays made by injection of contrast material into these ducts. X-rays of the bile ducts are known as cholangiograms and x-rays of the pancreatic ducts (the duct that carries digestive enzymes from the pancreas to the small intestine) are pancreatograms. ERCP may be used to remove pancreatic duct stones and to biopsy suspicious tumors. ERCP is a more complex form of upper gastrointestinal endoscopy.

Definitions (continued)

Endoscopy. Procedure involving direct visual examination of a hollow organ like the esophagus, stomach or intestine. Most endoscopy is fiberoptic endoscopy, which means use of a flexible tube that can be manipulated. Some endoscopes have special names related to their function. For example, a fiberoptic endoscope used to see the inside of the colon is called a colonoscope and an endoscope used to see the inside of the bronchi of the lungs is a bronchoscope. Endoscopes usually permit their operators to do more than just look—typically, an endoscope can be used to take biopsies, photographs and inject drugs, oxygen, air or salt solution.

Enema. Procedure of injecting liquid into the rectum to facilitate x-rays or for other purposes.

Esophageal varices. Varicose veins along the inside surface of the esophagus.

Esophagitis. Inflammation of the esophagus. The most common cause of esophagitis is gastroesophageal reflux, movement of acid stomach contents up into the esophagus, known as “heartburn.”

Fatty cirrhosis. Disorder characterized by infiltration of the liver with yellow fat. May be a finding in alcoholism, but there are also other causes.

Fistula. Abnormal opening between internal body structures or from the inside to outside of the body.

Gallbladder. The small, muscular sac that stores bile. The gallbladder is located up close to the bottom of the liver.

Gastrectomy. Removal of a part of the stomach. A total gastrectomy means removal of the entire stomach.

Gastric ulcer. Area of tissue destruction in the mucosa of the stomach.

Gastroesophageal reflux (GER). Movement of acid stomach contents up into the esophagus, popularly known as heartburn. When GER is excessive and chronic it is referred to as *gastroesophageal reflux disease (GERD)*.

Gastrointestinal tract (GI tract). The stomach and intestines.

Gastroparesis. Paralysis of the muscles that normally contract the stomach. Gastroparesis is commonly caused by diabetes mellitus.

Glycogen storage diseases. Genetic metabolic disorders involving abnormal enzymes needed for the proper metabolism of glycogen.

Granulomatous colitis. Regional enteritis that affects the large intestine alone.

Guaiac testing. A simple method for testing for blood in the stool that can be performed at the bedside or used at home. However, many factors can cause false-positive results.

Hematocrit (Hct). The percentage of red blood cells in a volume of blood. For example, a hematocrit of 50% means that half of the blood volume is made up of red cells. In men, a normal Hct is about 42%–48% and in women about 38%–44% at sea level. At high altitudes, normal values are higher. Also known as the *volume of packed red cells (VPRC)*.

Hemochromatosis. A rare disorder resulting in deposits of an excessive amount of an iron compound (hemosiderin) in the cells of multiple organs, including the liver.

Hepatic encephalopathy. Brain dysfunction and mental confusion associated with advanced liver failure.

Hepatic enzymes. Liver enzymes such as aspartate aminotransferase (AST), alanine aminotransferase (ALT), serum glutamic pyruvic transaminase (SGPT), serum gamma glutamyl transpeptidase (GGT), alkaline phosphatase and lactic dehydrogenase (LDH). AST is also known as serum glutamic oxaloacetic transaminase (SGOT). SGPT is also known as *alanine aminotransferase (ALT)*.

Hepatitis. Inflammation of the liver. A common cause of hepatitis is alcohol abuse. Other causes include viruses, toxins and drugs.

Hyperglycemia. Abnormally high blood glucose.

Hypoalbuminemia. Decreased blood albumin levels.

Hypoglycemia. Abnormally low blood glucose.

Ileostomy. A surgically placed opening from the ileum of the small intestine through the abdominal wall to the outside of the body.

Ileum. Third part of the small intestine.

Inferior vena cava (IVC). Large vein carrying venous blood back to the heart from the lower part of the body.

Inflammatory bowel disease (IBD). Diseases causing inflammatory damage to the inner mucosal lining of the intestine. Examples of IBD are regional enteritis, granulomatous colitis and ulcerative colitis. Also known as *enterocolitis*.

Intestinal mucosa. The specialized layer of cells that line the inside of the intestine. It is vital to the absorption of nutrients from digested food.

Intestines. The intestines are the small intestine (duodenum, jejunum and ileum) and large intestine (colon). Also known as *bowels*.

Iris. Pigmented eye muscle that controls the size of the pupil.

Iritis. Inflammation of the iris; may be caused by a number of different diseases.

Jejunum. The second part of the small intestine.

Ketosis. The production of excessive amounts of chemicals called ketone bodies, associated with severe and uncontrolled diabetes.

Laënnec's cirrhosis. Cirrhosis caused by alcoholism.

Liver enzymes. See *hepatic enzymes*.

Lower gastrointestinal (lower GI). Occurring in the large intestine.

Magnetic resonance imaging (MRI). Method of producing pictures of internal body structures using magnetic fields and radiofrequency fields. MRIs do not utilize x-rays or other radiation.

Malabsorption. Decreased ability to absorb nutrients from the intestine.

Definitions (continued)

Malassimilation. Decreased ability to transform absorbed nutrients into living tissue.

Melena. A black discoloration of feces resulting from the digestion of blood. Melena indicates bleeding somewhere in the upper gastrointestinal tract where blood can be digested.

Metabolic cirrhosis. Liver damage caused by metabolic diseases like *hemochromatosis*, *Wilson's disease*, and *glycogen storage diseases*.

Motility disorders. Disorders that interfere with normal movement of the esophagus, stomach or intestines. For example, diabetes mellitus may cause gastroparesis.

Mucosa. The layer of cells lining the inner surface of the mouth, esophagus, stomach and intestines.

Obstruction. Blockage.

Occult blood (stool). Blood that is present in such small quantities that melena is not visible to the eye. However, occult blood can be detected with guaiac and other tests.

Ostomy. Surgical procedure involving placement of an opening between hollow organs or to the outside of the body through the abdominal wall. For example, a colostomy is a surgically placed opening (stoma) from the colon through the abdominal wall.

Palpitations. Sensations in the chest of forceful, irregular or rapid heart beats.

Pancreatic duct. The duct carries digestive enzymes from the pancreas to the small intestine.

Pancreatic pseudocyst. An abnormal cavity in the pancreas, often as a result of abdominal trauma. The only difference between a pseudocyst and an ordinary cyst is that a pseudocyst is not lined with cells.

Pancreatitis. Inflammation of the pancreas. Common causes of pancreatitis are alcohol abuse and abdominal trauma.

Paracentesis. See *abdominal paracentesis*.

Peptic ulcer disease (PUD). Gastric ulcers (area of tissue destruction in the mucosa of the stomach) or duodenal ulcers (area of tissue destruction in the duodenum) caused by a combination of bacterial infection, acid and digestive enzymes.

Percentile. A percentile is a method of comparing something (like height or weight) to normal expected values, in order to decide the chance (probability) that it is normal or abnormal. For example, a person with a weight in the 60th percentile is heavier than 60% of other people and lighter than 40% of other people.

Plication procedure. A surgical procedure for tucking down esophageal varices to decrease the likelihood of rupture and bleeding.

Portacaval shunt. Surgically placed conduits between the portal vein and the inferior vena cava. The purpose of such shunts is to treat portal hypertension by lowering the pressure inside of the portal venous system.

Portal hypertension. High blood pressure inside the portal venous system. A common cause of portal hypertension is alcoholism.

Portal vein. The portal vein carries nutrient-rich blood from the intestine to the liver.

Prothrombin time (PT). Measurement of the blood coagulation activity of a liver-manufactured protein known as prothrombin. In advanced liver disease, the prothrombin time increases. Normal PT is about 11–14 seconds. The PT must be interpreted in terms of a “control value” that is always included in the laboratory report. To be normal, the PT should be less than two seconds longer than the control.

Rectum. The rectum is the final section of the large intestine.

Reflux esophagitis. Inflammation of the esophageal mucosa as a result of the movement of acid stomach contents back up into the esophagus.

Regional enteritis. Inflammatory disease of unknown cause principally affecting the small intestine. When regional enteritis affects both the small and large intestines it is known as ileocolitis. Regional enteritis affecting the large intestine alone is called granulomatous colitis. Regional enteritis may also produce inflammation of the eye (iritis) and arthritis.

Serum. The clear liquid part of blood after clotting. Most blood tests measure values in serum.

Shunt procedures (as used by digestive system listings).

Surgeries connecting the portal venous system to another venous system in order to lower the pressure inside of the portal vein. For example, a portacaval shunt connects the portal vein to the inferior vena cava. By decreasing the pressure inside of the portal venous system, esophageal varices are made less likely to rupture and bleed. See *portal hypertension*.

Stenosis. Narrowing.

Stoma. An opening, usually referring to the opening of an ostomy, such as a colostomy or ileostomy. The opening between two pieces of intestine that have been surgically connected (anastomosis) is also referred to as a stoma.

Stricture. Type of narrowing caused by scarring—a *cicatricial stenosis*.

Ulcerative colitis. An inflammatory disease of unknown cause affecting the large intestine. If the disease is confined to the rectum, it is known as *ulcerative proctitis*.

Ultrasound (of abdomen). Procedure using high-frequency sound reflected from structures inside the abdomen to construct images. Abdominal ultrasound is quick, painless and safe. Ultrasound studies may be directed toward specific structures such as the liver.

Upper gastrointestinal (upper GI). Occurring in the stomach or small intestine. The esophagus is usually included in the meaning of the term. For example, bleeding in the esophagus is usually considered an upper GI hemorrhage.

Upper gastrointestinal endoscopy. Fiberoptic endoscopic examination of the esophagus, stomach and small intestine.

Definitions (continued)

Can be used to diagnose and even treat a number of disorders including esophageal varices, esophageal tumors, esophagitis, esophageal scarring with narrowing (stricture), peptic ulcers and bleeding sites. Also known as *esphagogastroduodenoscopy (EGD)*.

Upper gastrointestinal series (upper GI series). X-rays taken after the patient swallows barium x-ray contrast material. The esophagus, stomach and small intestine can be visualized on these x-rays.

Vagotomy and pyloroplasty (V & P). Vagotomy means surgically cutting branches of the vagus nerve that go to the stomach and that are involved in the stimulation of acid secretion from glands in the stomach. A pyloroplasty is an incision into and surgical reconstruction the bottom part of the stomach (pylorus) to relieve obstruction caused by peptic ulcer disease. Vagotomy and pyloroplasty surgery has become uncommon with the development of powerful medications to control acid secretions from the stomach.

Varicose vein. Enlarged vein.

Wilson's disease. A very rare genetic disorder causing abnormal copper metabolism and resulting in the deposit of an excessive amount of copper in multiple organs, including the liver.

A. General Information

The digestive system is a long series of tubes and pouches that transport, process and absorb nutrients from food. The digestive process starts in the mouth and ends in the small intestine. The large intestine does not digest food; its purpose is essentially water absorption and storage. Absorption of food nutrients occurs only in the small intestine; there is no food absorption in the stomach.

The SSA considers digestive system disorders to fall into three broad categories:

- Interference with nutrition, such as occurs with malabsorption syndromes.
- Multiple recurrent inflammatory lesions, such as occurs with inflammatory bowel diseases like regional enteritis.
- Complications of disease, such as abscesses, fistulas or intestinal obstruction.

Most digestive disorders respond to treatment, and therefore few people satisfy the 12-month duration requirement to receive disability. In other situations, the SSA may predict that improvement will take place even if you are markedly impaired at the time of application for disability. The people

most likely to qualify for disability have a long documented history of digestive problems that satisfy the severity of the listings.

Some common digestive system disorders are rarely disabling. Frequently, individuals with colostomies or ileostomies have no significant functional limitations regarding the ability to work. Some claimants who have had these surgical procedures, however, have special problems with care of the abdominal surgical opening (stoma) or malnutrition associated with their underlying disorder and surgery. The symptoms of dumping syndrome rarely produce significant functional limitations nor do they last 12 months. Peptic ulcer disease usually responds to treatment, even if recurrent after surgery.

Nonetheless, digestive-related nutritional disorders in children can affect growth and development. Also, children may have congenital malformations of the digestive tract that require surgical intervention at an early age.

Documentation of digestive system disorders must include history and physical examinations, x-rays, surgical findings, endoscopic reports or biopsy reports that objectively demonstrate such disease to be present.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 5.02: Upper Gastrointestinal Bleeding (Adults)

This listing concerns only bleeding from the upper part of the GI tract, which means the esophagus, stomach or small intestine. The most common causes of such bleeding are peptic ulcers and ruptured esophageal varices. Most sources of upper GI bleeding can be identified and controlled with treatment in far less than 12 months. This listing applies only to those rare cases in which the bleeding site cannot be found and in which serious bleeding continues to be a problem. Such bleeding is evidenced by the presence of anemia as measured by the hematocrit (Hct).

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have recurrent upper GI bleeding from an undetermined cause with anemia manifested by a hematocrit of 30% or less on repeated examinations. The SSA does not define the term “recurrent.” Medical judgment must be applied on an individual basis, depending on how much the disorder affects your ability to function. The more severe and prolonged the anemia, the fewer episodes it would take to be disabling. In order for the hematocrit to remain 30% or less for 12 months as a result of bleeding, there would either have to be persistent bleeding or fairly frequent episodes of bleeding.

b. Residual Functional Capacity

The SSA has no definite rules, but if you have an unidentified source of upper GI bleeding, it is doubtful that you should receive an RFC for heavy work. If you are young, otherwise healthy and your hematocrit is nearly normal you might be able to tolerate medium work. However, once your hematocrit drops to a persistent level of 35% or lower your RFC should be light work or less. If your Hct is persistently close to that required by the listing—that is, 31% or 32%—a sedentary RFC would be reasonable. The SSA should take into account several other factors when determining your RFC:

- Your RFC may be reduced by the fatigue resulting from anemia.
- The more severe your anemia, the faster your resting heart rate as your body attempts to compensate for your anemia. Because your heart must work harder, it will have less reserve for exercise.
- An unidentified source of upper GI bleeding could be worsened by excessive exertion because an increase in blood pressure normally accompanies exertion.
- Other disorders, such as heart or lung disease, may be worsened by anemia.

Individuals differ in their response to anemia. Young people tend to tolerate anemia much better than older people do. Also, a person can adjust better to anemia resulting from slow blood loss than a sudden loss.

2. Listing 5.03: Narrowing or Obstruction of the Esophagus (Adults)

Partial or complete obstruction of the esophagus can result from stenosis caused by stricture, tumors or other diseases that injure the esophagus. For example, reflux esophagitis can damage the inner mucosal surface of the esophagus

resulting in esophageal narrowing over a period of years. Connective tissue diseases such as progressive systemic sclerosis (PSS) can result in fibrotic degeneration of the esophagus so that it becomes narrowed. Whatever the cause, long-term narrowing of the esophagus even in the absence of complete obstruction may be severe enough to make adequate nutrition difficult. For purposes of the listing, the cause of esophageal obstruction is not as important as the malnutrition it causes.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have partial or complete obstruction of the esophagus, by any disorder, that produces weight loss qualifying under Listing 5.08. The esophageal disorder must be documented with x-rays or by direct visualization with endoscopy.

b. Residual Functional Capacity

Your RFC depends not only on your weight, but also on your overall nutritional state and the underlying cause of the esophageal obstruction. A person with esophageal narrowing caused by acid reflux from the stomach might be able to eat by having their esophagus periodically dilated. A narrowing caused by an esophageal cancer may produce numerous other problems, however, such as treatment side effects, an abnormal metabolic state induced by the cancer and severe pain. Similarly, a claimant with esophageal narrowing caused by a connective tissue disease like progressive systemic sclerosis can have numerous other problems related to that disorder which increase overall severity. Medical judgment must be applied on an individual basis.

3. Listing 105.03: Narrowing or Obstruction of the Esophagus (Children)

The comments under Listing 5.03 apply here. Additionally, children may have congenital narrowing of the esophagus or even absence of the esophagus (esophageal atresia). Also, drinking caustic liquids like lye can cause severe scarring and consequent narrowing of the esophagus.

a. Listing Level Severity

For a child's condition to be severe enough to meet the listing, the child must have partial or complete obstruction of the esophagus by any disorder that produces weight loss qualifying under Listing 105.08. The esophageal disorder must be documented with x-rays or by direct visualization with endoscopy.

4. Listing 5.04: Peptic Ulcer Disease (Adults)

Peptic ulcer disease (PUD) refers to ulcers in the stomach or duodenum occurring as a result of several factors, including digestive enzymes, stomach acid and the presence of a particular type of bacteria (*Helicobacter pylori*). The major risk of PUD is life-threatening bleeding, and PUD is a frequent cause of upper GI bleeding. If an ulcer is known to be the source of bleeding, it can almost always be controlled. Unknown causes of bleeding are considered under Listing 5.02.

The listing requires that PUD be proven, not merely suspected. That requires x-rays by an upper gastrointestinal series or endoscopy.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have peptic ulcer disease as demonstrated by x-rays or by direct visualization with endoscopy. Additionally, you must satisfy **A**, **B**, **C** or **D**, below.

- A** Recurrent ulceration after definitive surgery persistent despite therapy. The recurrence must be demonstrated by x-rays or endoscopy, just as the original ulcer must be proven to exist. Impairment resulting from ulcer recurrence must be expected to last 12 months. Definitive surgery is that which was intended to control the ulcer, such as vagotomy and pyloroplasty or partial (subtotal) gastrectomy.
- B** Inoperable fistula. For example, an ulcer might penetrate from inside to outside of the small intestine where it starts and then penetrate from outside to inside of another nearby piece of intestine. This could leave a fistula between the insides of the two areas of intestine that would normally not be present. Or the ulcer could penetrate the intestine and become attached to the pancreas, resulting in a fistula between the two. This would be a quite serious and painful situation. A fistula might be inoperable if, for example, scarring from the ulcer and prior surgeries contraindicate attempts at further repair.
- C** Recurrent obstruction of the intestine demonstrated on x-rays or endoscopy. Such obstruction would most likely be caused by scarring related to the ulcer, even if the ulcer itself were successfully treated. Ulcers that occur repeatedly are probably more likely to result in this situation, as well as larger ulcers.
- D** Weight loss as described under Listing 5.08. Malnutrition could be an issue with PUD. It is important that your weight be accurately measured without shoes or other significant clothing that would falsely add to your weight and work to your disadvantage.

b. Residual Functional Capacity

Medical judgment must determine your RFC for a case of PUD that is not severe enough to meet a listing. Factors to be considered include your functional limitations imposed by pain and other symptoms, the number and length of your hospitalizations, your responses to treatment and especially your weight as an indication of nutritional state and strength. See the RFC discussion under Listing 5.08.

When the SSA first created this listing, highly effective drugs now used to control stomach acidity were not available. Also, medicine did not know how bacteria contribute to ulcers; today, the offending bacteria can be eradicated to decrease the chance of recurrence. It is unusual for a person to satisfy this listing if that person has received proper medical care and also complied with the prescribed treatment.

5. Listing 5.05: Chronic Liver Disease (Adults)

Most adult claimants alleging disability on the basis of liver disease have alcoholic liver damage, either as alcoholic liver inflammation (alcoholic hepatitis) or fibrous shrinkage of the liver secondary to alcohol abuse known as alcoholic cirrhosis.

Many other disorders can damage the liver, including genetic disorders, toxins, poisons, drugs, bacterial infections, heart failure, fungi, ulcerative colitis, parasites and viruses. Viral hepatitis may be caused by hepatitis viruses A, B, C, D, E or G. Other viral infections can affect the liver but are not classified as viral hepatitis types. Chronic active hepatitis and chronic persistent hepatitis can result from infectious or toxic insults to the liver.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have chronic liver disease. Additionally, you must satisfy **A**, **B**, **C**, **D**, **E** or **F**, below.

- A** Esophageal varices (demonstrated by x-rays or endoscopy) with a documented history of massive hemorrhage attributable to these varices. You would be considered disabled for three years following the last massive hemorrhage; thereafter, the SSA would evaluate the residual impairment. This listing recognizes that portal hypertension resulting from cirrhosis can cause varicose veins in the esophagus, which then have a tendency to bleed. The SSA does not define massive hemorrhage, but hospitalization and blood transfusion would probably be required.
- B** Performance of a shunt operation for esophageal varices. You would be considered disabled for three years following surgery; thereafter, the SSA would evaluate the

residual impairment. You satisfy this listing if your condition is so severe that you required surgery for a shunt operation—such as a portacaval shunt—to decrease pressure in your portal venous system and lower the risk of bleeding from esophageal varices.

- Ⓒ Serum total bilirubin of 2.5 mg/100 ml (2.5 mg/deciliter) or greater that persists on repeated examinations for at least five months. Total bilirubin is divided into direct (conjugated) and indirect (unconjugated) bilirubin. The SSA must use the total; partial values will be lower and your claim could be erroneously denied. The SSA does not define repeated examinations; medical judgment must be applied. Advanced liver disease with extremely high bilirubin blood levels would most likely last at least five months, but this is affected by the prognosis for the particular liver disease. In all cases, a blood test of bilirubin levels must be made sometime near the beginning and end of the five-month period.
- Ⓓ Ascites, not attributable to other causes, recurrent or persisting for at least five months, demonstrated by abdominal paracentesis or associated with hypoalbuminemia of 3.0 grams/100 ml (3.0 grams/deciliter) or less. Ascites can be suspected on physical examination by a doctor; however, the listing requires confirmation by paracentesis (done by your treating doctor) or by measurement of blood albumin. Albumin tends to decline when you have ascites.
- Ⓔ Hepatic encephalopathy. This would be evaluated under the criteria of mental disorder listing 12.02 (Chapter 27). Hepatic encephalopathy is a state of confusion associated with elevated levels of blood ammonia, which the diseased liver cannot handle.
- Ⓕ Confirmation of chronic liver disease by liver biopsy. Because the SSA will not order you to undergo a liver biopsy, this listing applies only if your treating doctor has done one. You must also satisfy 1, 2 or 3.
 1. Ascites, not attributable to other causes, recurrent or persisting for at least three months, demonstrated by abdominal paracentesis or associated with hypoalbuminemia of 3.0 grams/100 ml (3.0 grams/deciliter) or less. This is the same as part Ⓓ, except only three months is required.
 2. Serum total bilirubin of 2.5 mg/100 ml (2.5 mg/deciliter) or greater on repeated examinations for at least three months. This is the same as part Ⓒ, except only three months is required.
 3. Hepatic cell death (necrosis) or inflammation (hepatitis), persisting for at least three months, documented by repeated abnormalities of prothrombin time (PT) and elevated enzymes indicative of liver dysfunction. Laboratories vary widely on the expected normal

values of hepatic enzymes because of differences in measurement techniques. Test report results, however, should include normal values against which the results can be compared. It is not necessary that all of the various types of enzymes be measured. AST or ALT would normally be sufficient.

b. Residual Functional Capacity

Many different RFC levels are possible, depending on the severity of the liver disease. Medical judgment must be applied on the basis of the underlying liver disease, nutritional state, prognosis and your symptoms. Easy fatigability, nausea and abdominal pain may be limiting factors. If your liver is extremely enlarged, you must be careful to avoid abdominal trauma because of the danger of rupture. If you have ascites, it is doubtful the SSA should give you an RFC for more than light work. The SSA needs to know how your daily activities are affected—preferably in your treating doctor's medical records. For example, does nausea limit your eating? Do you get tired and short of breath with certain activities? What activities?

6. Listing 105.05: Chronic Liver Disease (Children)

Many disorders can damage a child's liver, including genetic disorders, toxins, poisons, drugs, bacterial infections, heart failure, fungi, ulcerative colitis, parasites and viruses. Viral hepatitis may be caused by hepatitis viruses A, B, C, D, E or G. Other viral infections can affect the liver but are not classified as viral hepatitis types. Chronic active hepatitis and chronic persistent hepatitis can result from infectious or toxic insults to the liver.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have chronic liver disease. Additionally, the child's condition must satisfy Ⓐ, Ⓑ, Ⓒ, Ⓓ, Ⓔ or Ⓕ, below.

- Ⓐ Inoperable biliary atresia demonstrated by x-ray or surgery. Biliary atresia is a genetic disorder characterized by an absent bile duct system in the liver.
- Ⓑ Ascites not responding to treatment and not attributable to other causes. A serum albumin of 3.0 grams/100 ml (3.0 grams/deciliter) or less must also be present. Ascites is a sign of advanced liver disease and will result in a low serum albumin blood test.
- Ⓒ Esophageal varices demonstrated by angiography, barium swallow, endoscopy or by prior performance of a specific shunt or plication procedure. If one of the tests does not show the disease, a shunt or plication pro-

cedure is sufficient proof because the surgery otherwise would not have been performed. Unlike adults, bleeding from the varices is not required.

- Ⓓ Hepatic coma, documented by findings from hospital records.
- Ⓔ Hepatic encephalopathy evaluated under mental Listing 112.02. (See Chapter 27.)
- Ⓕ Chronic active inflammation or liver cell death documented by a SGOT, persistently measuring 100 units or a serum bilirubin of 2.5 mg/100 mg (2.5 mg/deciliter or 2.5 mg/dl) or greater.

7. Listing 5.06: Chronic Ulcerative or Granulomatous Colitis (Adults)

Ulcerative and granulomatous colitis are inflammatory diseases of unknown cause that affect the large intestine. They may be associated with several symptoms and other abnormalities that result in disability. The diagnosis must be first established by one of the methods mentioned in the listing, however.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have chronic ulcerative or granulomatous colitis (demonstrated by endoscopy, barium enema, biopsy or operative findings) along with Ⓐ, Ⓑ, Ⓒ, Ⓓ or Ⓔ, below.

- Ⓐ Recurrent bloody stools documented on repeated examinations and anemia manifested by a hematocrit of 30% or less on repeated examinations. Bloody stools not only indicate uncontrolled disease, but also can result in significant blood loss. The SSA does not define recurrent; medical judgment is applied case by case. The more severe and prolonged the anemia, the fewer episodes would be required to be disabling. A minimum of three different hematocrits, reasonably spread out over three to six months, is required to conclude that the severity will last a year.
- Ⓑ Persistent or recurrent systemic manifestations, such as arthritis, iritis, fever or liver dysfunction, not attributable to other causes. The SSA does not define recurrent; medical judgment is applied case by case. The more severe and prolonged the abnormalities, the fewer episodes would be required for the disease to be disabling.
- Ⓒ Intermittent obstruction due to abscesses, fistula formation or narrowing of the intestine that does not respond to treatment. The SSA does not define intermittent; medical judgment must be applied case by case. The more severe and prolonged the abnormalities, the fewer episodes would be required for the disease to be disabling.

- Ⓓ Recurrence of findings of part Ⓐ, Ⓑ or Ⓒ after total colectomy. The colon is called the target organ for ulcerative or granulomatous colitis, and improvement would normally be expected after its removal. Recurrence, even once, of any of the abnormalities Listed in part Ⓐ, Ⓑ or Ⓒ despite colectomy is a sign of continuing disabling severity.
- Ⓔ Weight loss as described under Listing 5.08. Malnutrition with significant weight loss can be a significant problem. Your weight must be accurately measured without shoes or other significant clothing that would falsely add to your weight and work to your disadvantage.

b. Residual Functional Capacity

No absolute RFCs exist. The SSA applies medical judgment to each case depending on the nature of the underlying disorder, symptoms, functional limitations, treatment response and prognosis. Also see the discussion of RFC under Listing 5.08. If you are anemic, see the discussion of RFC under Listing 5.02.

8. Listing 5.07: Regional Enteritis (Adults)

Regional enteritis is an inflammatory disease of unknown cause affecting the small intestine. When regional enteritis affects only the large intestine it is known as granulomatous colitis, which is evaluated under Listing 5.06. When regional enteritis affects both the small and large intestines it is known as ileocolitis, which can be evaluated under either listing.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have regional enteritis (demonstrated by findings during surgery, endoscopy, x-rays with barium contrast or biopsy). Additionally, you must satisfy part Ⓐ, Ⓑ, Ⓒ or Ⓓ below.

- Ⓐ Persistent or recurrent intestinal obstruction. The SSA must have evidence of clinical abnormalities expected of obstruction—abdominal pain, abdominal distention, nausea and vomiting. X-ray findings of obstruction must also be present: dilation of the intestine just before the obstruction. Obstruction results from the inflammatory nature of the disease that can produce scarring, abscesses or fistulas. The SSA does not define recurrent; medical judgment must be applied case by case. The more severe and prolonged your abnormalities, the fewer episodes would be required to be considered disabling.
- Ⓑ Persistent or recurrent systemic manifestations such as arthritis, iritis, fever or liver dysfunction, not attributable to other causes. The SSA does not define recurrent; medical judgment must be applied case by case. The

more severe and prolonged the abnormalities, the fewer episodes would be required to be disabling.

- Ⓒ Intermittent intestinal obstruction due to abscess or fistula formation. Unlike part Ⓐ, clinical abnormalities such as nausea and vomiting are not required. The SSA does not define recurrent; medical judgment must be applied case by case. The more severe and prolonged the abnormalities, the fewer episodes would be required to be disabling.
- Ⓓ Weight loss as described under Listing 5.08. Malnutrition with significant weight loss can be a significant problem. Your weight must be accurately measured without shoes or other significant clothing that would falsely add to your weight and work to your disadvantage.

b. Residual Functional Capacity

No absolute RFCs exist. The SSA applies medical judgment to each case depending on the nature of the underlying disorder, symptoms, functional limitations, treatment response and prognosis. Also see the discussion of RFC under Listing 5.08. If you are anemic, see the discussion of RFC under Listing 5.02.

9. Listing 105.07: Chronic Inflammatory Bowel Disease (Children)

Chronic inflammatory bowel disease (chronic IBD) usually means ulcerative colitis, regional enteritis or granulomatous colitis. Any inflammatory disorder of the intestine, however, could qualify. In addition to the complications that can afflict adults with IBD, children may also suffer decreased growth as a result of such chronic disease.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have chronic inflammatory bowel disease (demonstrated by findings during surgery, endoscopy, x-rays with barium contrast or biopsy). Additionally, the child's condition must satisfy Ⓐ, Ⓑ, or Ⓒ, below.

- Ⓐ Intestinal manifestations or complications, such as obstruction, abscess or fistula formation that has lasted or is expected to last 12 months.
- Ⓑ Malnutrition as described under Listing 105.08.
- Ⓒ Growth impairment as described in Listing 100.03. (See Chapter 16.)

10. Listing 5.08: Weight Loss (Adults)

Weight loss is a potentially disabling problem that most digestive system disorders have in common. A wide variety of medical problems can result in weight loss; it is very important in disability determination.

When medical evidence has established a primary or secondary digestive tract disorder, the resultant interference with nutrition is considered under this listing. The difference between primary or secondary digestive disorders is made by the SSA, but it is not necessary for you to understand. You just need to know that any physical disorder that sufficiently interferes with the function of the digestive tract can potentially satisfy this listing.

Examples of primary gastrointestinal (GI) disorders that can cause weight loss include:

- Various forms of inflammatory bowel disease, such as regional enteritis and ulcerative colitis.
- Inflammation of the mucosa lining the inside of the intestines.
- Chronic inflammation of the pancreas (chronic pancreatitis). When the pancreas is damaged, it cannot produce the digestive enzymes needed for digestion or absorption.
- Surgical removal of stomach or intestine (gastrointestinal resection). This can result in a limited ability to intake adequate amounts of food as well as a decrease in the amount of intestine available for the digestion of food and the absorption of food nutrients.
- Esophageal stenosis, including narrowing caused by scarring (stricture).
- Disorders resulting in the intestinal mucosa's malabsorption of nutrients, including bacterial growth in the small intestine, drugs, genetic diseases, damage by radiation, parasitic infections, diabetes mellitus, inflammatory bowel diseases, autoimmune disorders and surgery on the GI tract. Decreased pancreatic function, such as that caused by cystic fibrosis, may also result in malabsorption.
- Disorders resulting in the body's malassimilation of nutrients, including chronic kidney failure and cancer. Type I diabetes mellitus can also cause malassimilation.
- Obstructions in the digestive tract such as by tumors, abscesses or stenosis that interfere with the ability to get food to locations where it can be properly digested and absorbed. For example, chronic peptic ulcer disease (PUD) may cause not only pain that discourages adequate food intake, but also scarring in the stomach or upper part of the small intestine which interferes with food transit from the stomach into the intestines.
- Loss of appetite accompanying digestive system disorders. Chronic illness itself may cause anorexia.
- Pain associated with digestive disorders causing restriction of food intake, especially if eating causes increased pain. Most serious digestive system disorders cause pain.

Weight loss caused by nondigestive system impairments, such as hormonal or mental disorders, should be evaluated under the appropriate listings for those disorders. One exception is Type I (juvenile) diabetes, a hormonal disorder caused by the immune system's damage to the insulin-producing cells of the pancreas with resultant decrease in the production of insulin and an abnormal metabolic state. Type I diabetes is considered by part ④ of the listing. Understand that Type II (adult onset) diabetes is a different disease, and usually associated with obesity, not weight loss.

Another exception is the serious mental disorder known as anorexia nervosa. A person with anorexia nervosa would probably be granted benefits under a mental disorder listing. In addition, persistence of weight loss under Tables I or II (part A of the listing) is justification for an allowance, even with no physical disorder.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have weight loss due to any persisting gastrointestinal disorder. (The weights in Tables I–IV must have persisted for at least three months despite prescribed therapy and must be expected to persist for at least 12 months.) You must also satisfy ① or ②, below.

Note that the tables list whole numbers only. Many people's heights or weights fall in between the figures given in the tables. If your height is one-half inch or more over a value, the SSA should use the next higher value. For example, if you are 67.5 inches, consider yourself 68 inches. This is to your advantage in that you can weigh three pounds more at 68 inches than 67 inches and still qualify under the listing.

If your weight is less than one-half of a value, the SSA should use the lower value. For example, if you weigh just under 109.5 pounds, consider yourself 109 pounds.

Paying attention to such details can easily make the difference between being granted and being denied benefits. Say you are a male with the height and weight given above, 67.5 inches and 109.5 pounds. Without rounding off both values, you would fail to qualify under Table I; by rounding off you would be granted benefits. Do not assume that the SSA will pay attention to such detail.



Accuracy is important. Height and weight must

be accurately documented in medical records. The SSA often has trouble determining height and weight because of the different values reported in various records. If you are at your treating doctor's office, hospital or other health facility or at a consultative examination for the SSA, make sure that your height and weight are actually measured—don't give some numbers you think are accurate and let them be written into your record. Your height should be measured without shoes, and you should

not be weighed with any more clothing than is required for modesty—a couple of pounds of excess clothing, or heavy items in your pockets, can erroneously put you over the weight tables.

① Weight equal to or less than the values specified in Table I or Table II.

Table I—Men

Height (inches, no shoes)	Weight (pounds)
61	90
62	92
63	94
64	97
65	99
66	102
67	106
68	109
69	112
70	115
71	118
72	122
73	125
74	128
75	131
76	134

Table II—Women

Height (inches, no shoes)	Weight (pounds)
58	77
59	79
60	82
61	84
62	86
63	89
64	91
65	94
66	98
67	101
68	104
69	107
70	110
71	114
72	117
73	120

② Weight equal to or less than the values specified in Table III or IV. Also 1, 2, 3, 4, 5, 6 or 7 must be satisfied.

1. Serum albumin of 3.0 grams per deciliter (3.0 gm/100 ml) or less.
2. Hematocrit of 30% or less. This indicates anemia.

3. Serum calcium of 8.0 mg per deciliter (8.0 mg/100 ml or 4.0 meq/L) or less. This indicates poor nutrition.
4. Uncontrolled diabetes mellitus due to abnormal function of the pancreas, with repeated episodes of hyperglycemia, hypoglycemia or ketosis.
5. Fat in stool of seven grams or greater per 24-hour stool specimen. This indicates malabsorption of fat.
6. Nitrogen in the stool of three grams or greater per 24-hour specimen. This indicates malabsorption of proteins.
7. Persistent or recurrent ascites or edema not attributable to other causes. This can indicate advanced protein malnutrition.

Table III—Men

Height (inches, no shoes)	Weight (pounds)
61	95
62	98
63	100
64	103
65	106
66	109
67	112
68	116
69	119
70	122
71	126
72	129
73	133
74	136
75	139
76	143

Table IV—Women

Height (inches, no shoes)	Weight (pounds)
58	82
59	84
60	87
61	89
62	92
63	94
64	97
65	100
66	104
67	107
68	111
69	114
70	117
71	121
72	124
73	128

b. Residual Functional Capacity

Your degree of weight loss, the disease causing your weight loss and your symptoms all influence the RFC.

Medical judgment is applied case by case; the SSA has no specific rules for RFCs in weight loss impairments. If you are close to the severity of the listing, however, your RFC should be for sedentary work at most. This would be the case, for example, if your weight is a few pounds over the requirement in Table I or II, or if your weight qualifies in Table III or IV, but you don't meet the laboratory values under part ③ 1-7.

If anemia is a problem for you, also see the discussion of RFC under Listing 5.02.

11. Listing 105.08: Weight Loss (Children)

The comments under Listing 5.08 regarding gastrointestinal disorders apply here. Because a child's normal weight varies with age, percentile rankings are used instead of tables of weights. A child old enough—such as a teenager—to satisfy the heights in Tables I-IV of Listing 5.08 can be evaluated under that listing. Any doctor who treats children should have a standard growth chart. You child's doctor should also have a record of your child's weight at different ages. If the doctor has not kept good records, your child's disability decision could be delayed, because the SSA needs several weights over a period of months to verify the persistence of the malnutrition.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have malnutrition due to gastrointestinal disease with either:

- weight loss resulting in a fall of at least 15 percentiles on standard growth charts which persists, or
- persistence of weight that is less than the third percentile on standard growth charts.

Additionally, the child's condition must satisfy ①, ②, ③ or ④, below.

① Stool fat excretion per 24 hours satisfying 1, 2 or 3.

1. More than 15% in infants less than six months.
2. More than 10% in infants six to 18 months.
3. More than 6% in children more than 18 months.

② Persistent hematocrit of 30% or less despite prescribed therapy.

③ Serum carotene of 40 micrograms (mcg)/100 ml or less.

④ Serum albumin of 3.0 grams/100 ml or less.

12. Listing 5.09: Liver Transplant (Adults)

About 87% of patients survive for one year after a liver transplant. At five years, the post-transplant survival rate de-

creases by approximately 10%. In adults, acquired disorders like alcoholic cirrhosis and viral hepatitis are the main causes of liver failure and the need for transplantation. In children, liver failure is more commonly caused by a genetic disorder (especially failure of the bile ducts to develop, a disorder known as biliary atresia). Although most livers are transplanted from deceased donors, an increasingly popular option is to receive part of a living donor's liver.

As with other types of organ transplants, the major problem is suppression of the immune system, a deliberate medical step to prevent rejection of the graft. Unfortunately, this suppressed immunity can lead to the development of serious infections: viral, fungal, bacterial and parasitic. Immune suppression also increases the chances of developing cancer, particularly lymphoma.

Other side effects of the medications and other risks are the same as those found with all organ transplants, such as the development of osteoporosis, cataracts (resulting from corticosteroids), intense itching, kidney and brain toxicity, nausea, vomiting, diabetes and high blood pressure.

Liver transplants require close monitoring for immune rejection and other complications, particularly infections. The first year after transplantation is particularly important, although problems can develop at any time.

a. Listing Level Severity

If you have had a liver transplant, the SSA will automatically consider you to be disabled for one year following surgery. After that, your residual impairment will be evaluated under

whatever listings are appropriate to your particular situation, such as those covering the digestive system.

You qualify for these first 12 months of disability benefits without any restrictions whatsoever. For example, you could be feeling great eight months after surgery and your doctor could even tell the SSA she thinks you could work. But you would still qualify under the listing, if you wished to make use of your benefits.

b. Residual Functional Capacity

Because you're automatically entitled to benefits, no RFC applies to liver transplants. After the required 12 months have gone by, your case will be evaluated under whichever listings are appropriate to your circumstances. The SSA is hesitant to terminate SSA benefits to people who've received liver transplants, unless the person himself, and his doctor, think he's ready to return to some kind of work. Still, there is a good possibility that you could feel much improved and return to light work after a liver transplant.

13. Listing 105.09: Liver Transplant (Children)

The comments under Listing 3.11 for adults apply here, even though the particular types of liver disease that may lead to a transplant often differ in children.

a. Listing Level Severity

A child is considered disabled for one year following surgery and, like adults, no other medical factors can alter this qualification. After that, the child's residual impairment is evaluated under whatever digestive system or other listings are appropriate.



Chapter 21

Kidney Diseases

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Albumin. Protein made only in the liver that accounts for half of the protein in the blood stream. Serves as a carrier for numerous bodily substances, as well as some drugs. Normal albumin levels are about 3.5–5.0 grams/deciliter (gm/dl or gm/100 ml).

Anasarca. Severe form of edema in which the entire body is swollen from the retention of water.

Anemia. Low red blood cell count, usually determined by a decrease in the hematocrit.

Anorexia. Loss of appetite. Anorexia is a frequent problem in chronic disorders, including advanced kidney disease.

Autoimmune diseases. Disorders of the immune system, characterized by the body erroneously reacting to some of its own tissues as foreign (antigens). Antigen-antibody complexes can damage organs such as the kidneys.

Biopsy. The process of taking a sample of tissue for detailed analysis of various kinds. Biopsy specimens are observed grossly with the eyes, microscopically with a variety of possible tissue stains and in some cases may involve specific chemical and DNA analysis.

Creatinine. Waste product of muscle metabolism that is normally filtered out of the blood by the kidneys. Therefore, serum creatinine levels provide information about the functional state of the kidneys. Normal serum creatinine is about 0.5–1.5 mg/dl (0.5–1.5 mg/100 ml).

Creatinine clearance. Amount of blood per minute that is cleansed of creatinine by the kidneys. It is measured by taking both blood and urine samples. In males, normal creatinine clearance is about 125 ml/min/1.73 m² body surface area and in females about 115 ml/min/1.73 m². In many adults, the body surface area in interpreting creatinine clearance is not critical to accuracy, but must be used for children.

Cyst. Closed cavity, usually containing fluid. Benign cysts of the kidney are common in middle-aged individuals. Also see *polycystic kidney disease* and *renal osteodystrophy*.

Dialysis. Artificial removal of metabolic waste products from the blood. See *hemodialysis* and *peritoneal dialysis*.

Diastolic blood pressure. Pressure inside arteries during the time between heart beats. The diastolic pressure is the second number in a blood pressure reading. For example, 120/80 means the diastolic blood pressure is 80 mm Hg.

Edema. Excessive fluid retention in a tissue, such as peripheral edema in the legs or pulmonary edema in the lungs. See *vascular congestion*.

Glomeruli. Microscopic, round tufts of arteries in the filtering units of the kidney (nephrons). Each nephron has one

glomerulus. It is the blood flowing through the glomeruli that is filtered of waste materials.

Glomerulonephritis. Kidney disease characterized by inflammatory damage to the glomeruli.

Hematocrit (Hct). The percentage of red blood cells in a volume of blood. For example, a hematocrit of 50% means that half of the blood volume is made up of red cells. In men, a normal Hct is about 42%–48% and in women about 38%–44% at sea level. At high altitudes, normal values are higher. Also known as the *volume of packed red cells (VPRC)*.

Hemodialysis. Direct dialysis of the blood to remove metabolic waste products that cannot be cleared by diseased kidneys. Blood is usually obtained for dialysis by surgically sewing an artery and vein together in the wrist. Such a shunt provides easy permanent access to blood, which is then removed, circulated through a machine and returned to the body.

Hydronephrosis. Kidney damage caused by the inability of urine to drain properly through the ureters to the bladder. Blockage of a ureter could be caused by kidney stones, pressure from tumors in the ureter or tumors pressing on the ureter from outside. Infection or other diseases of the ureter causing scarring and narrowing could also interfere with the normal flow of urine through it.

Hyperlipidemia. Excessive amount of blood fats (lipids), including cholesterol and triglycerides.

Hypertension. High blood pressure. Hypertension usually means systemic hypertension—high blood pressure in the arterial system of the body other than the lungs. Hypertension in adults is defined as any pressure of 140/90 or greater. In children, normal expected blood pressure varies with age.

Hypoalbuminemia. Decreased blood albumin levels.

Metabolism. The total chemical and physical activity of the body associated with the production and maintenance of life.

Nephritis. General term meaning inflammation of a kidney. Diseases that affect the glomeruli of the kidneys are types of glomerulonephritis. Bacterial infection of a kidney is known as pyelonephritis. Diseases affecting the cells between the nephrons are called interstitial nephritis.

Nephrolithiasis. Kidney stones. The danger of nephrolithiasis is obstruction of urine flow and development of hydronephrosis. Nephrolithiasis can block urine flow either within the kidney itself or move into and block the ureter that drains the kidney to the bladder.

Nephrons. The microscopic filtering units of kidneys. Each kidney has about one million nephrons.

Nephrotic syndrome. A condition resulting from kidney disease with proteinuria, hypoalbuminemia (decreased blood albumin levels), edema and hyperlipidemia (excessive amount of blood fats).

Neuropathy. Any disease of peripheral nerves. Peripheral nerves are those connecting the spinal cord to the various

Definitions (continued)

organs and tissues of the body. Kidney failure is one possible cause of neuropathy. Neuropathy is best demonstrated by weakness, decreased reflexes, loss of sensation and decreased nerve conduction velocity (NCV). Motor neuropathy means that affecting the motor nerves which carry impulses away from the spinal cord to stimulate muscles. Sensory neuropathy means that affecting the sensory nerves which carry touch, pain, vibration, limb position, heat and cold sensations from the tissues of the body to the spinal cord for transmission to the brain. Not every type of sensation need be affected by the neuropathy.

Pericarditis. Inflammation of the pericardial membrane that surrounds the heart. There are many possible causes of pericarditis, including kidney failure.

Peritoneal dialysis. Method of removing waste products from the blood by placing fluids (dialysis solution or dialysate) in the abdominal cavity. Waste products in the blood such as urea cross the peritoneal membrane lining the abdominal cavity and enter the fluid, which can then be withdrawn and discarded after a certain amount of time. In intermittent peritoneal dialysis (IPD), dialysis solution is infused into the abdominal cavity through a catheter (hollow artificial tube), then removed in about 20 minutes and the procedure repeated several times. Multiple cycles of treatment weekly are usually required, the number depending on the severity of the kidney disease. IPD is done in special facilities. In continuous ambulatory peritoneal dialysis (CAPD), the patient performs his or her own dialysis. Fresh dialysis solution is put in the abdominal cavity three to four times daily, after removing the prior instilled solution. In this way, a patient can lead a more normal life. Continuous cycling peritoneal dialysis (CCPD) involves peritoneal dialysis at nighttime with the assistance of a machine to carry out several exchanges of dialysis fluid. Some dialysis fluid is also left in the abdominal cavity during the day.

Pleural effusion. Collection of fluid between the inside of the chest wall and the outer surface of the lungs.

Polycystic kidney disease. Genetic disorder characterized by the replacement of normal kidney tissue with multiple cysts.

Proteinuria. Excessive loss of protein in the urine as a result of kidney disease. The main protein lost is albumin.

Pruritus. Itching.

Pulmonary edema. Collection of fluid within the lungs.

Pyelonephritis. Bacterial infection of a kidney.

Renal. Referring to the kidney.

Renal osteodystrophy. Abnormal bone caused by kidney disease and consisting of several abnormalities. Osteitis fibrosa cystica is a form of fibrous bone degeneration with bone cysts. Osteoporosis refers to thinning of the substance of bone. Pathologic fractures are breakage of bone with minimal trauma that would not break normal bones and results from osteitis fibrosa cystica and osteoporosis.

Stenosis. Narrowing.

Ureters. Tubes that carry urine from the kidneys to the bladder. Each kidney normally has one ureter, although some people have an extra one.

Urethra. Tube that carries urine from the bladder to exit the body.

Urinary tract. Kidneys, ureters (tubes that carry urine from the kidneys to the bladder), bladder, urethra (tube that carries urine from the bladder to exit the body).

Vascular congestion. Retention of excessive fluid in blood vessels, which then leaks to other tissues. If sufficiently severe, vascular congestion can cause swelling in the hands or feet (peripheral edema), excessive fluid in the lungs (pulmonary edema), swelling along the shin (tibia) known as pretibial edema, swelling in the lower back area (presacral edema), fluid accumulation in the pleural space between the inner chest wall and the surface of the lungs (pleural effusion), puffiness around the eyes (periorbital edema) and fluid accumulation in the abdomen (ascites).

A. General Information

Sometimes kidney failure is short term, and such acute kidney failure will not satisfy the disability requirement that an impairment last at least 12 months. This disability is for irreversible (chronic) kidney disease. The SSA requires both of the following to determine chronic kidney disease:

- History, physical examination and laboratory evidence of kidney disease.
- Indications of the worsening nature of the kidney disease, such as laboratory evidence of deteriorating kidney function. Laboratory evidence of particular interest to the SSA are kidney function blood tests, such as the serum creatinine, creatinine clearance and kidney biopsies. Because biopsies are invasive, the SSA will not request that they be done. If your treating physician has done a biopsy, however, make sure the SSA has the results, including a description of the microscopic findings.

1. Causes of Kidney Failure

Several disorders can cause chronic renal disease, including diabetes, infections (parasitic, viral and bacterial), drug use, exposure to toxic heavy metals, hereditary disorders such as polycystic kidney disease, autoimmune diseases such as systemic lupus erythematosus and inflammation of arteries, and cancers such as leukemia, lymphoma and solid tumors. These examples also have the potential to cause nephrotic syndrome (see just below). Chronic renal failure may also result from high blood pressure, polycystic kidney disease, hydronephrosis and nephrolithiasis.

2. Nephrotic Syndrome

Nephrotic syndrome is not itself a kidney disease, but a malfunction of the kidney that may be of unknown origin, or may occur as a result of a specific renal disease. Most of the protein lost in the urine in nephrotic syndrome is albumin. Decreased blood albumin results in edema with the associated swelling in the feet, hands, around the eyes, lower back or face.

The amount of protein loss in nephrotic syndrome is usually greater than three grams per day, which is much higher than normal. Serum albumin is usually decreased to less than 2.5 grams per 100 ml serum (2.5 g/dl). The severity of proteinuria is related to body size, and so corrections for body surface are sometimes necessary. These corrections are especially important in children because body size can differ greatly at different ages.

Nephrotic syndrome may be accompanied by a fall in blood pressure while standing (orthostatic hypotension) or blood clots (venous thromboses).

3. Urinary Tract Disorders

Although the listings concern disease of the kidneys, keep in mind that disorders of the urinary tract can limit a claimant's ability to work. One example is interstitial cystitis (IC), an inflammation of the urinary bladder. IC is of unknown cause, usually begins in middle age and affects about 500,000 people in the U.S.—about 90% women. IC may be misdiagnosed as a bladder infection because of the burning pain and need to urinate frequently to relieve the pain. IC is a much more serious disorder than a simple urinary tract infection, however, and severe cases can be functionally debilitating. Many treatments have been tried with variable success.

Diagnosis of IC depends on direct visualization of the mucosa lining the inside of the bladder and can be done with a procedure known as cystoscopy. A bladder biopsy is usually done to rule out other disorders like cancer, but a biopsy cannot reliably be used to determine the severity of the IC. Diet, other medical disorders, emotional and physical stress, allergies and medications may trigger worsening of symptoms. About half of IC patients describe their pain as severe or excruciating. Urinary frequency in severe cases consists up to 60 trips to the bathroom a day and sleep deprivation from needing to urinate multiple times nightly. Associated pain can be severe. Pain during sexual intercourse affects a majority of patients with IC, but would not be considered by the SSA to be functionally limiting for disability determination purposes.

If you have IC, clearly and fully document the nature of your symptoms and exactly how these symptoms limit your ability to function. Your treating doctors must be able to support your allegations, along with your treatment failures or successes. The most debilitating cases of IC might be considered of equivalent severity to Listing 6.02, although the kidneys are fine. Other cases might sufficiently limit your ability to perform particular types of jobs and qualify you on a medical-vocational basis.

The SSA should apply reasonable medical judgment to each case individually, even if the medical disorder is not specifically given in the Listings of impairments. IC is just one example.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 6.02: Chronic Kidney Disease (Adults)

Many medical disorders can cause chronic renal failure (CRF), as noted above under General Information. Any type of kidney disease can qualify under this listing as long as it results in chronic kidney disease of the severity required by the listing. Acute kidney failure, such as severe dehydration, viral infection or drug toxicity, cannot qualify under this listing unless the damage becomes irreversible.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have decreased kidney function, due to any chronic kidney disease that is expected to last 12 months. Additionally, you must satisfy **A**, **B** or **C**, below.

- A** Chronic hemodialysis or peritoneal dialysis necessitated by irreversible renal failure. Chronic dialysis is a condition that qualifies you for benefits because permanent dialysis is only done in irreversible kidney failure. Also, dialysis is so time-consuming that most people cannot receive daily dialysis and work. Some people on chronic ambulatory peritoneal dialysis are able to work, but that is a matter of choice. All forms of chronic dialysis qualify. You have to actually be receiving dialysis—planned dialysis does not qualify. Nor does short-term dialysis.
- B** Kidney transplant. SSA would consider you to be under a disability for 12 months following surgery. A kidney transplant must actually have been done, not simply planned or anticipated. Benefits for 12 months after a transplant are automatically granted, because of the possibility of complications. These include infection, rejection of the transplanted kidney, the side effects of drugs (steroids or other immune-suppressing drugs), and other facets of kidney failure such as anemia and damage to the peripheral nervous system. However, you are not required to have any complications to qualify. After the 12-month recovery period, you'll be examined again to

determine if you have reached a stable state of improvement.

- C** Persistent increase of serum creatinine to 4 mg/100 ml or greater (4 mg/dl) or reduction of the creatinine clearance to 20 ml/minute (29 liters/24 hours) or less; these laboratory abnormalities must be present at least three months. The listing anticipates possible complications of chronic kidney disease lasting at least three months evidenced by at least two serum creatinine or creatinine clearance measurements. If the serum creatinine or the creatinine clearance are sufficiently abnormal, then you must also satisfy 1, 2, 3, 4, 5, 6 or 7.
 1. Renal osteodystrophy, manifested by severe bone pain and x-ray abnormalities such as osteitis fibrosa cystica, osteoporosis or pathologic fractures. Not all bone abnormalities that chronic kidney disease can cause need be present on an x-ray, but a doctor must be able to conclude that the x-rays show kidney-related bone disease.
 2. An episode of pericarditis. It doesn't matter when it occurred as long as it was related to kidney disease and is in your medical records. Proof does not have to be made by a biopsy of the pericardium; reasonable symptoms, physical examination and laboratory evidence are enough.
 3. Persistent motor or sensory neuropathy. Decreased ability to feel touch, heat or vibration can suggest damage to sensory nerves—complete numbness is not required. Damage to motor nerves can produce muscle weakness, but not all muscles need be involved. Complete paralysis of a muscle is unnecessary. In other words, the severity of the motor or sensory neuropathy isn't specified; it must be more than slight or mild. A test called a nerve conduction velocity study is more accurate than a physical examination. The SSA can order this test done if it was not performed by your treating doctor.
 4. Intractable pruritus. Pruritus—severe, persistent itching—may accompany chronic kidney disease, and can be very troublesome. There are no objective tests for pruritus; your treating doctor must have pruritus documented in your medical records.
 5. Persistent fluid overload syndrome resulting from diastolic hypertension (110 mm Hg or above) or signs of vascular congestion. Poorly functioning kidneys do not adequately clear the body of water through the formation of urine. This may be demonstrated in two ways: (1) edema, as shown on physical examination or a chest x-ray showing pleural effusion or pulmonary edema, or (2) a high diastolic blood pressure resulting from overloading the vascular system with

water. The persistence should be thoroughly documented in your medical records.

6. Persistent anorexia with recent weight loss and current weight meeting the values in Listing 5.08 (see Chapter 20), Table III or IV. This listing recognizes the fact that malnutrition from loss of appetite and abnormal metabolism is a serious problem in chronic kidney disease.
7. Persistent hematocrits of 30% or less. In chronic kidney disease, anemia results from loss of a hormone produced in the kidney that stimulates the bone marrow to make red blood cells. Fortunately, modern genetic engineering has created the needed hormone (erythropoietin) and its use can markedly improve the anemia of renal failure. Hematocrits would have to be measured over a period of at least three months to establish the persistent anemia required by the listing.

b. Residual Functional Capacity

RFCs for CRF are determined on a case-by-case basis. You must let the SSA know exactly how your daily activities are limited. If you have bone pain, neuropathy, weight loss or anemia, do you have the strength to stand and walk six to eight hours a day? If not, your RFC should be reduced to sedentary work. Does swelling in your feet affect your ability to wear shoes? Do you have neuropathy in your hands that affects your ability to handle small objects, like picking up coins or buttoning your clothes? Are you distracted by severe itching—for example, does it keep you from getting restful sleep? Do you have side effects from drugs? Do you get tired vacuuming, cooking, driving, shopping or engaging in social or other activities? Is your treating doctor aware of your limitations and, if so, are they recorded in your medical records?

Anemia is the most important cause of fatigue in CRF. The SSA has no definite rules, but if you have CRF with anemia and hematocrits in the 31–33% range, it is doubtful you can do more than sedentary work. If you are anemic, the SSA should take into account two important factors when determining your RFC:

- The fatigue resulting from anemia.
- Your heart rate. The more severe your anemia, the faster will be your resting heart rate as your body attempts to compensate for your anemia. Because your heart has to work hard, it will have less reserve for exercise.

2. Listing 106.02: Chronic Kidney Disease (Children)

The discussion under Listing 6.02 applies here.

a. Listing Level Severity

The child's condition must satisfy ①, ②, ③ or ④, below.

- ① Persistent elevation of serum creatinine to 3 mg/100 ml (3 mg/dl) or greater over at least three months. The SSA will require at least two creatinine measurements over a three-month period to show persistence of the kidney disorder.
- ② Reduction of creatinine clearance to 30 ml per minute (43 liters/24 hours) per 1.73 m^2 of body surface area over at least three months. As with part ①, the SSA will require at least two creatinine measurements over a three-month period to show persistence of the kidney disorder. The SSA or your treating doctor will have to adjust the results to your child's body surface area.
- ③ Chronic hemodialysis or peritoneal dialysis necessitated by irreversible renal failure. Chronic dialysis is a condition that qualifies for benefits because permanent dialysis is only done in irreversible kidney failure. Also, dialysis is so time-consuming that most children cannot engage in normal activities appropriate for their age and receive daily dialysis. All forms of chronic dialysis qualify. The child has to actually be receiving dialysis—planned dialysis does not qualify. Nor does short-term dialysis.
- ④ Kidney transplant. SSA will consider the child to be under a disability for 12 months following surgery. A kidney transplant must actually have been done, not simply be planned or anticipated. Benefits for 12 months after a transplant are automatically granted, because of the possibility of post-surgery complications. These include infection, rejection of the transplanted kidney, the side effects of drugs (steroids or other immune-suppressing drugs) and other facets of kidney failure such as anemia and damage to the peripheral nervous system. However, the child is not required to have any complications to qualify. After the 12-month recovery period, the child will be examined again to determine if he has reached a stable state of improvement.

3. Listing 6.06: Nephrotic Syndrome (Adults)

Nephrotic syndrome is associated with kidney diseases that permit an excessive loss of protein (albumin) into the urine. See the discussion of nephrotic syndrome under “General Information.”

Granting benefits under this listing is rare because most cases of nephrotic syndrome can be controlled by treatment, and the requirement for persistent total body edema is difficult to satisfy. The listing assumes that three months of failed treatment are an indication that impairment will be expected to last 12 months. If you have nephrotic syndrome, your treating doctor should have done all the necessary tests to make the diagnosis.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have nephrotic syndrome with significant anasarca, which has been persistent for at least three months despite prescribed therapy. Additionally, you must satisfy ① or ②, below.

- ① Serum albumin of 3 grams/100 ml (3 grams/dl) or less and proteinuria of at least 3.5 grams per 24 hours. This part requires a blood test and a 24-hour urine collection.
- ② Proteinuria of at least ten grams per 24 hours. This part requires only a urine collection, but with much larger amounts of protein being lost in the urine than under part ①. To see if you qualify, you can check the test result numbers in your medical records against those in the listing. The SSA may need more up-to-date information than is in your file, however, and require that the tests be done again.

b. Residual Functional Capacity

The RFC discussion under Listing 6.02 applies here. RFC restrictions must be adjusted to the type of kidney disease causing the nephrotic syndrome and the symptoms. For example, a pleural effusion or pulmonary edema can cause shortness of breath, fluid in the abdomen can cause pain and swelling in the knees may decrease ability to stand and walk or use leg controls. You may also suffer loss of appetite and weakness related to muscle wasting. If you are retaining fluid, you can be more malnourished and weaker than would otherwise be supposed from your weight. Your

blood pressure may be too high or too low, and you may have trouble with physical exertion.

Most important is for the SSA to know how your daily activities are limited and why. To the extent that your medical records and treating doctor support your statements about your limitations, your case will be stronger. The most critical factor is whether you can stand and walk six to eight hours daily. If you cannot, your RFC would be reduced to sedentary work. Each case is evaluated based on the particular abnormalities present, however there are far too many possibilities to have any set rules for RFC.

4. Listing 106.06: Nephrotic Syndrome (Children)

The comments under Listing 6.06 apply here. Note that while the adult listing requires total body edema, this listing requires only that some edema be present—and therefore could be mild. Nevertheless, granting benefits under this listing is unusual because most cases of nephrotic syndrome in children can be controlled with treatment.

Although not stated by this listing, the SSA generally requires the abnormalities to be present for a minimum of three months before deciding that the child's disability is likely to last a year.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have nephrotic syndrome with edema not controlled by prescribed therapy. Additionally, the child's condition must satisfy ① or ②, below.

- ① Serum albumin less than 2 grams/100 ml (2 grams/dl).
- ② Proteinuria of more than 2.5 grams per 1.73 m² body surface area per 24 hours. This part measures protein loss in the urine. It is important to supervise urine collections in children because incomplete collections will give falsely low values that could result in erroneous denial of the claim. The SSA or your treating doctor will have to adjust the results to your child's body surface area. ■

Chapter 22

Blood and Lymphatic Diseases

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Allergen. Substances that trigger an allergic immune reaction, such as pollen, molds, certain drugs, insect venom and dust.

Anemia. Low red blood cell count, usually determined by a decrease in the hematocrit.

Antigens. Substances that trigger the body's immune system. Antigens are usually foreign substances such as allergens, bacteria or viruses, but there are also autoimmune disorders in which the immune system mistakenly reacts to its own tissues as if they were antigens.

Aplastic anemia. Any anemia resulting from decreased red blood cell production by the bone marrow. There are many possible causes of aplastic anemia, such as drugs, infection, radiation, cancer and toxic substances.

Autoimmune disorders. Disorders in which a person's immune system forms antibodies against their own tissues.

Biopsy. The process of taking a sample of tissue for detailed analysis of various kinds. Biopsy specimens are observed grossly with the eyes, microscopically with a variety of possible tissue stains and in some cases may involve specific chemical and DNA analysis.

Blast crisis. See *leukemia*.

Bone marrow. Material inside of some bones that produces white blood cells, red blood cells and platelets.

Bone marrow aspiration. A procedure involving suction of a sample of liquid bone marrow cells into a syringe, after penetrating the overlying bone with a special large needle. Bone marrow aspiration is often done in association with bone marrow biopsy.

Bone marrow biopsy. Procedure involving taking a small core of solid bone and underlying marrow so that the structure remains intact.

Cerebrospinal fluid (CSF). Fluid that flows around and within the spinal cord and brain, providing moisture and cushioning.

Cerebrovascular accident (CVA). Stroke. There are basically two kinds of stroke: hemorrhagic strokes caused by bleeding in the brain and thrombotic strokes caused by blockage of blood flow to a part of the brain.

Chronic. Persistent.

Coagulation. Clotting of blood.

Coagulation factors. Proteins that are necessary for the clotting of blood.

Complete blood count (CBC). Test providing information about the numbers and types of white blood cells, the numbers of red blood cells and how much hemoglobin they contain, the hematocrit and the platelet count.

Electrophoresis. Method of identifying substances by the different distances they move when subjected to an electric field. Electrophoresis is usually performed on serum or urine samples. If the reactions of antibodies are combined with electrophoretic testing, the test is said to be immunoelectrophoresis.

Erythrocytosis. Increased red blood cell count.

Fibrosis. Degenerative process involving the replacement of normal tissue with fiber-like tissue.

Granulocytopenia. Decreased numbers of granulocytes. Granulocytes are neutrophils, basophils and eosinophil types of white blood cells.

Heavy chain disease. A disorder of plasma cells (plasma cell dyscrasia) associated with the production of fragments of antibodies. There is more than one type of heavy chain disease, depending on the type of antibody involved.

Hemarthrosis. Bleeding into a joint space.

Hematocrit (Hct). The percentage of red blood cells in a volume of blood. For example, a hematocrit of 50% means that half of the blood volume is made up of red cells. In men, a normal Hct is about 42–48% and in women about 38–44% at sea level. At high altitudes, normal values are higher. Also known as the volume of packed red cells (VPRC).

Hemoglobin (Hb). The oxygen-carrying chemical in red blood cells.

Hemoglobinopathy. Any disorder involving the production of an abnormal type of hemoglobin. For example, sickle cell anemia is a hemoglobinopathy.

Hemolysis. Condition characterized by the destruction of red blood cells. Hemolysis can be caused by a number of disorders, such as immune diseases, drugs, poisons and genetic disorders.

Hemolytic anemia. Anemia caused by hemolysis.

Hemophilia. Any of the genetic disorders characterized by insufficient production of coagulation factors.

Hereditary telangiectasia. A genetic disorder associated with areas of malformation and dilation (enlargement) of small blood vessels. Hereditary telangiectasias can affect any organ or other living tissue.

Hypercalcemia. Increased blood calcium. Normal serum calcium is about 8–10 mg/dl.

Idiopathic. Of unknown cause.

Immunoglobulin (Ig). A chemical produced by plasma cells that is part of the body's immune response to antigens. Immunoglobulins perform many specialized functions. The various types immunoglobulins are G, M, A, D and E. These are abbreviated as IgG, IgM, IgA, IgD and IgE. Also known as *antibodies*.

Infarction. Death of a piece of tissue as a result of insufficient blood flow.

Definitions (continued)

Intracranial bleeding. Hemorrhage occurring within the skull. Intracranial bleeding inside the brain is called intracerebral bleeding.

Lesion. Abnormality.

Leukemia. Any of the of white blood cell cancers arising in the bone marrow or lymph nodes. Specific leukemias are named according to which type of white cell is involved, such as lymphocytic leukemia and myelocytic leukemia. Leukemia is also classified as acute or chronic. Acute leukemias are those with the most cancerous cells, while chronic leukemias have more normal cells.

Leukocytes. See *white blood cells*.

Leukocytosis. Increased white blood cells, not specific in regard to what type of white cell is involved.

Lymph. A usually transparent liquid that comes from tissue fluids and also contains lymphocytes originating in lymph nodes.

Lymphangiography. X-rays of the lymphatic system following the injection of x-ray contrast material.

Lymphangitis. Inflammation of a lymphatic vessel as could occur with infection.

Lymphedema. Swelling of tissues caused by retention of lymph fluid.

Lymph nodes. Specialized collections of cells found in various locations along the system of lymph vessels.

Lymphoblasts. Immature lymphocytes.

Lymphocytes. Specialized white cells that play important roles in the function of the immune system involving both cells (cellular immunity) and antibodies (humoral immunity). Lymphocytes are found in the bone marrow, blood and lymphatic system.

Lymphocytopenia. Decreased numbers of lymphocytes in the blood.

Lymphocytosis. Increased numbers of lymphocytes in the blood or other fluid.

Lymphoma. Cancer of the lymph nodes and spleen that results in abnormal lymphocytes. Lymphoma can invade any organ of the body. Hodgkin's lymphoma and Non-Hodgkin's lymphoma are two important lymphomas.

Lymphoproliferative disorders. See *lymphomas*.

Lymphoscintigraphy. Method of visualizing lymph nodes by injection of a radioactive substance and making images of lymph nodes that concentrate the radioactivity. Lymphoscintigraphy is used for detecting spread of cancer to lymph nodes.

Macroglobulinemia. Disorders associated with the production of excessive amounts of immunoglobulin M antibody (IgM). Macroglobulinemia involves an abnormality of plasma cells (plasma cell dyscrasia).

Monocytes. A types of white blood cells with immune functions. For example, some monocytes change into macrophages. Macrophages engulf (eat) bacteria and other abnormal material.

Myelofibrosis. A disorder of several different causes associated with loss of normal bone marrow and replacement with fibrosis.

Myeloma. A form of cancer involving excess production of plasma cells by the bone marrow. Also known as *multiple myeloma*.

Myeloproliferative disorders. Disorders that involve the proliferation of bone marrow cells, in or outside of the marrow. For example, multiple myeloma and leukemia are myeloproliferative disorders.

Neutropenia. Decreased numbers of blood neutrophils.

Neutrophils. Type of white blood cell important in fighting infection.

Osteomyelitis. Infection of bone.

Osteosclerosis. Bone abnormality associated with myelofibrosis. Osteosclerosis may be seen on x-rays, as areas of increased bone density.

Packed red cells. Concentrated red blood cells for transfusion.

Peripheral blood. Blood that is circulating in the arteries and veins, outside of the bone marrow.

Petechiae. Pinpoint-sized spots of bleeding into the skin, which are red to purple in color. They may be a physical sign of thrombocytopenia.

Phlebotomy. The controlled removal of blood, usually from a vein.

Plasma. The clear liquid (non cell) part of blood before clotting.

Plasma cells. Type of white blood cell normally found in bone marrow and lymph nodes, but not circulating blood. Plasma cells make antibodies. (**Note:** plasma and plasma cells are not related.)

Plasma cell dyscrasias. Disorders involving abnormal plasma cell function, like excessive antibody production (such as macroglobulinemia) or abnormal pieces of antibodies (as in heavy chain disease).

Plasmapheresis. Method for removing substances from the blood, involving the following steps: (1) Blood is taken from the body; (2) the plasma is separated from the cells by spinning in a centrifuge; and (3) blood cells are reinjected along with fresh replacement plasma or albumin. Plasmapheresis is usually done on an outpatient basis. Plasmapheresis can either be used to remove unwanted substances from blood (such as elevated cholesterol) or to harvest plasma blood components for donation to patients who need them.

Platelet count. Normal platelet counts are about 150,000–300,000 per mm³.

Polycythemia. Polycythemia rubra vera is a serious disease of the bone marrow resulting in erythrocytosis, leukocytosis, thrombocytosis and increased blood volume. Also known as *primary* or *absolute polycythemia*. Far less serious is secondary

Definitions (continued)

polycythemia, where increased numbers of red cells in a body attempt to improve the oxygenation of tissues. Secondary polycythemia is frequently seen in people with advanced lung disease.

Purpura. Small spots of bleeding into the skin, red to purple in color. They are larger than a petechia, but not over about one centimeter in diameter. Purpura may be a sign of thrombocytopenia. Purpura may refer to only one spot or multiple spots. A purpura caused by trauma rather than decreased platelets is a bruise.

Red blood cells (RBCs). Cells made in the bone marrow that have the major function of oxygen transport by means of the hemoglobin they contain.

Reticulocytes. Immature forms of red blood cells.

Serum. The clear liquid part of blood after clotting.

Sickle cell anemia. An inherited red blood cell defect in which red cells are unusually susceptible to destruction. Sickle cell anemia is a type of hemoglobinopathy because it involves the production of an abnormal form of hemoglobin called sickle hemoglobin.

Sickle cell preparation. A fast screening test for sickle cell anemia.

Splenomegaly. Enlarged spleen.

Systemic. Affecting the whole body.

Thalassemia. Any of the disorders in which parts of the hemoglobin molecule are made at a decreased rate.

Thrombocytopenia. Decreased numbers of platelets.

Thrombocytosis. Increased numbers of blood platelets.

Thrombosis. Formation of a blood clot.

White blood cells (WBCs). White blood cells consist of neutrophils, lymphocytes, basophils, eosinophils and monocytes. Also known as *leukocytes*.

Whole blood. Blood without alteration from its natural state.

nodes stationed along lymphatic vessels function for the immune system and contain lymphocytes. Lymph nodes can trap and destroy bacteria. Lymph nodes can also catch cancerous cells that are being spread through the lymphatic system. Therefore, biopsy of lymph nodes is important in determining whether cancer has spread (metastasized) from the original tumor. Lymphangiography and lymphoscintigraphy are also useful tests in detecting lymphatic disease such as spreading cancer. Lymphangitis, cancer and associated treatments and trauma can damage the lymphatic system and produce lymphedema. The swelling caused by lymphedema can result in functional limitations.

A prediction that a condition will last the required 12 months must be based on at least three months of medical documentation. Medical documentation of blood or lymphatic disorders always involves laboratory tests, and such tests must include the values reported on more than one examination over that three-month period.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 7.02: Chronic Anemia (Adults)

The most frequent cause of anemia in the United States is iron deficiency in women. This disorder is seen frequently by the SSA, but is usually easily treated and is rarely a basis for disability. The many possible causes of anemia include infections, drugs, toxins, autoimmune diseases, vitamin deficiencies, genetic blood disorders such as sickle cell anemia and cancer. This listing is applicable to any kind of anemia that is severe and lasts, or is expected to last, 12 months.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have chronic anemia due to any cause with a hematocrit persisting at 30% or less. Additionally, you must satisfy **A** or **B**, below.

A. General Information

Blood consists of red cells that carry oxygen; white cells, which are important in immunity and fighting infection; and platelets, which help prevent abnormal bleeding. In addition, the liquid part of blood (plasma) carries numerous substances, such as proteins (like albumin), vitamins, minerals, glucose and fats. Blood is formed in the marrow of bone. Marrow is found in bone cavities, but is not present in all bones.

The lymphatic system circulates lymph fluid separately from the vascular system of blood vessels, but lymph fluid does empty into the bloodstream in several locations. Lymph

- Ⓐ You have had one or more blood transfusions on an average of at least once every two months. Whole blood or packed red cell transfusions qualify. To determine the frequency of the transfusions, divide the duration of your anemia in months by the number of incidents in which transfusion was required. Count one incident as one transfusion, even if more than one unit of blood was given. For example, say you were hospitalized twice in six months, requiring two units of blood during one hospitalization and one unit of blood during the other. Your anemia would not qualify under this listing because you cannot divide six months by your three blood transfusions and come up with an average of a transfusion every two months. Instead, you must count the two units during the first hospitalization as one transfusion, for an average of one transfusion every three months.

A need for transfusions to keep your hematocrit up to 30% implies that without the transfusions your anemia would be much worse. Also, your hematocrit will go down, reflecting a need for transfusion, and then rise up to a correct level after the transfusion. Because of the rise and fall, you will be considered more impaired than people with a steady hematocrit of 30%.

- Ⓑ Other impairments associated with the anemia should be evaluated under the criteria of whatever listings are appropriate. For example, sickle cell anemia can cause strokes and should be evaluated under Listing 11.04 (Chapter 26).

b. Residual Functional Capacity

The major limiting factors in anemia are weakness and easy fatigability. This is because fewer red cells than needed are carrying oxygen to the body's tissues. Also, the heart rate increases in an attempt to compensate for the anemia, meaning the heart has less reserve to handle exertion. For example, if your resting heart rate is increased to 100 beats per minute because of anemia, you've already used up a significant amount of your heart rate reserved for exercise. Still, anemia affects each person differently. A young person is less affected than an elderly one, as are people in better overall physical condition.

If your hematocrit is only a couple of percentage points below normal, you would not have any restrictions—assuming that is your only problem. On the other hand, if your hematocrit is only a couple of percentage points over that required by the listing—say 33%—but otherwise you qualify under Part Ⓐ, your RFC should be for no more than sedentary work. Of course, if you suffer from other impairments, the SSA should consider the effect of your anemia upon them. For example, the limitations imposed by heart

or lung disease can be markedly worsened by the presence of significant anemia.

2. Listing 107.03: Hemolytic Anemia (Children)

The many possible causes of hemolytic anemia include drugs, autoimmune diseases, infection and genetic disorders. Genetic disorders resulting in easily destructible red blood cells are a significant cause of hemolytic anemia in children. Such disorders may make the red cells more susceptible to rupture by affecting the outer membranes of red cells or by producing abnormal forms of hemoglobin within the red cells (hemoglobinopathies) or by causing deficiencies of important enzymes that red cells need to function. A common type of genetic hemolytic anemia resulting from hemoglobinopathy is sickle cell anemia; for children, that disorder is separately considered under Listing 107.05.

Reticulocytes, or immature red cells, are confined mostly to the bone marrow. When the bone marrow struggles to turn out new red cells to make up for those destroyed by hemolysis, however, reticulocytes are released into the blood stream in larger numbers. Normally, the reticulocyte count in peripheral blood is in the 0.5–2.5% range and averages about 1.5%. A percentage increase is a sign of continuing destruction of red cells and that the anemia has not been controlled. A reticulocyte count is part of a complete blood count (CBC).

Two important enzyme deficiencies in children causing hemolytic anemia are pyruvate kinase deficiency and glucose-6-phosphate dehydrogenase (G-6-PD) deficiency. You don't need to know the details; but if your doctor diagnoses your child with either disease, the disorder would be evaluated under this listing.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have hemolytic anemia due to any cause, manifested by the persistence of a hematocrit of 26% or less despite prescribed therapy. Additionally, the child's reticulocyte count must be 4% or greater.

3. Listing 7.05: Sickle Cell Disease (Adults)

Sickle cell disease is often seen by the SSA in both children and adults. All of the sickle cell diseases are hemoglobinopathies because they involve abnormal sickle hemoglobin (Hb S) in red blood cells. Sickle cell disease is also a type of hemolytic anemia because the Hb S makes red cells delicate and susceptible to easy destruction.

Normal adult hemoglobin is known as hemoglobin A. If you inherit genes for normal hemoglobin from both parents,

all of your hemoglobin will be normal (Hb AA). Infants have fetal hemoglobin (Hb F), but this is normally rapidly replaced with adult hemoglobin.

If you inherit genes to make sickle hemoglobin from both parents, all of your hemoglobin will be abnormal (Hb SS) and you have sickle cell anemia. If one parent gives you a gene for normal hemoglobin (Hb A) and the other gives you a gene for sickle hemoglobin (Hb S), you will end up with half of each (Hb AS) and you will have sickle cell trait. The distinction between these two disorders is important, because sickle cell trait does not cause significant symptoms or limitations. Sickle cell anemia, on the other hand, can cause numerous and serious problems which are considered by this listing.

There are other sickle cell diseases besides sickle cell anemia and sickle cell trait. A person could inherit Hb S from one parent and a different kind of abnormal hemoglobin from the other parent—for example, hemoglobin S and hemoglobin C (Hb SC). Hemoglobin SC disease results in abnormalities like sickle cell anemia, but generally less severe.

There is also a disorder called thalassemia. In thalassemia, the normal hemoglobin is made at a decreased rate. When a sickle hemoglobin gene is inherited from one parent and a thalassemia gene from the other, the result is fairly common disorder known as sickle thalassemia. Abnormalities are similar to sickle cell anemia, but generally milder.

A reliable way of diagnosing any type of sickle cell disease is by means of a test called hemoglobin electrophoresis. Hemoglobin electrophoresis separates and measures the types of hemoglobin present, using a blood sample. The SSA must have the results of hemoglobin electrophoresis to make an accurate diagnosis of sickle cell disease. A screening test called a sickle cell preparation is not acceptable as a means of diagnosing sickle cell disease.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have sickle cell disease or one of its variants. Additionally, you must satisfy ①, ②, ③ or ④, below.

- ① Documented painful thrombotic crises (also known as vaso-occlusive crises) occurring at least three times during the five months before disability determination. The sickle shape of the abnormal red blood cells makes it difficult for them to move through blood vessels and blood flow may be further worsened by clotting in the affected vessel. Complete blockage of blood flow results in death of the tissue served by that vessel. The associated symptoms depend on the organ involved and the size of the infarction. Bone infarctions can be quite painful; infarctions of the brain produce strokes; infarctions of

the heart may result in heart failure; infarctions of the lung can cause chest pain and pneumonia; and infarctions of the kidneys can result in kidney failure.

Bone infarction can be triggered by a number of things—most frequently exposure to cold—but also infection, dehydration and pregnancy. Painful bone infarctions can involve the spine, breastbone, long bones in the arms and legs, the ribs and pelvic bones. It is important that your treating doctor document your pain in your medical records.

- ② Sickle cell disease requiring extended hospitalization (beyond emergency care) at least three times during the 12 months before disability determination. Hospitalization may be required due to aplastic episodes, in which the hematocrit falls rapidly because of the bone marrow's inability to produce enough red cells. Hospitalization might also be the result of hyperhemolytic crises, in which the unusually rapid destruction of red cells causes a sudden fall in hematocrit. Other possible complications to sickle cell disease that could result in hospitalization include strokes, heart attacks, heart failure, kidney failure and pneumonia.
- ③ Chronic, severe anemia with persistence of hematocrit of 26% or less. The SSA should apply this requirement reasonably. For example, if your hematocrit values are consistently low with a single value of 27%, you should not be denied benefits. Remember that if your hematocrit is as high as 30%, you might still be granted benefits under Listing 7.02④ when you receive blood transfusions.
- ④ Evaluate the resulting impairment under the criteria for the affected body system. For example, a stroke would be evaluated under Listing 11.04 (Chapter 26) and a heart attack under the listings for heart disease (Chapter 19).

b. Residual Functional Capacity

The major limiting factors in anemia are weakness and easy fatigability. This is because fewer red cells than needed are carrying oxygen to the body's tissues. Also, the heart rate increases in an attempt to compensate for the anemia, meaning the heart has less reserve to handle exertion. For example, if your resting heart rate is increased to 100 beats per minute because of anemia, you've already used up a significant amount of your heart's reserve for exercise. Still, anemia affects each person differently. A young person is less affected than an elderly one, as are people in better overall physical condition.

If you have a hematocrit less than 30%, it is doubtful you could do more than sedentary work. If your sickle cell disease is sickle cell anemia, you should always avoid strenuous exertion and exposure to cold and your RFC

should be no higher than light work. The SSA has no definite rules, however, and each case must be evaluated on an individual basis.

4. Listing 107.05: Sickle Cell Disease (Children)

The comments under Listing 7.05 apply here.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have sickle cell disease or one of its variants. Additionally, the child's condition must satisfy Ⓐ, Ⓑ, Ⓒ, Ⓓ or Ⓔ, below.

- Ⓐ Recent, recurrent, severe vaso-occlusive crises involving the musculoskeletal system (including the spine) or abdominal organs (liver, spleen, etc.). This is similar to part Ⓐ under Listing 7.05. Neither recent nor recurrent are defined by the SSA. Medical judgment must be applied individually, depending on how much the disorder affects the child's ability to function. The more severe and prolonged the crises, the fewer episodes would be required to be disabling. Using adult Listing 7.05 as a guide, the child would have to have at least three episodes during the five months before disability determination.
- Ⓑ A major complication involving a large organ during the 12 months before application for disability benefits. Complications might include meningitis, lung infection (pneumonia) or infarction, osteomyelitis, heart failure, kidney infarction, liver infarction, intestinal infarction or cerebrovascular accident. A major complication would ordinarily be one that required hospitalization, although the listing includes no such requirement. The fact that the child may have improved by the time you apply for benefits does not prevent qualification. For example, the child may be doing well with a major complication six months in the past. But the child would still be entitled to disability because the 12-month allowance window is still in force.
- Ⓒ A hyperhemolytic or aplastic crisis within 12 months before the application for disability benefits. The fact that the child may have improved by the time you apply for disability does not prevent qualification.
- Ⓓ Chronic, severe anemia with persistence of hematocrit of 26% or less. This is the same as part Ⓒ under adult Listing 7.05.
- Ⓔ Congestive heart failure, strokes or emotional disorders as described under the criteria in the child listing for heart failure (104.02, Chapter 19), the appropriate child neurological listings (Chapter 26) or the appropriate

child mental disorder listings (Chapter 27). This is essentially the same as part Ⓓ under adult Listing 7.05.

5. Listing 7.06: Chronic Thrombocytopenia (Adults)

Several disorders, including leukemia, myelofibrosis, drugs, toxic substances, immune diseases and genetic disorders, can cause decreased platelets. This lowered platelet count (thrombocytopenia) can result in repeated episodes of serious, even life-threatening, bleeding. Furthermore, idiopathic thrombocytopenia is of unknown cause. Platelets circulating in the blood help prevent serious bleeding by sticking together at sites where bleeding tries to start; they are also important in starting the coagulation process. Platelet counts are easy to make with a sample of blood and are routinely done with a complete blood count (CBC). Spontaneous bleeding starts without any traumatic cause.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have chronic thrombocytopenia due to any cause, with platelet counts repeatedly below 40,000 per mm³. Additionally, you must satisfy Ⓐ or Ⓑ, below.

- Ⓐ At least one episode of spontaneous bleeding within five months of the date of disability determination requiring transfusion. The transfusion could be either packed red blood cells or whole blood. That you have improved after the transfusion does not prevent you from qualifying, as long as the transfusion was within five months of your application for disability benefits. Spontaneous bleeding is especially likely if the platelet count falls below 40,000 per mm³. A platelet count this low is life-threatening and should receive immediate treatment.
- Ⓑ Intracranial (within the head) bleeding within 12 months before disability determination. The severity of the intracranial bleeding or the degree to which you may have recovered when applying for disability does not matter, as long as the event occurred within the prior 12 months.

b. Residual Functional Capacity

The danger with thrombocytopenia is bleeding. Even though you may have the strength to do heavy work, to do so is probably too dangerous. Doing heavy lifting or working around heavy equipment occasionally results in physical trauma. What might ordinarily result in only a bruise in a normal person can cause severe internal bleeding if your platelet count is low. This is particularly true for blows to

the head. Even if a job does not involve heavy work, you should not perform work that has a significant danger of physical trauma such as falling or being cut. If your platelet count is only modestly decreased—say 100,000 mm³—you wouldn't need any restrictions because your chance of bleeding is not increased.

6. Listing 107.06: Chronic Idiopathic Thrombocytopenic Purpura (Children)

The comments about thrombocytopenia under Listing 7.06 are relevant to child applicants, although they are not exactly the same. Unlike the adult listing, this child listing concerns only one disorder involving a low platelet count—idiopathic thrombocytopenic purpura (ITP). ITP is of unknown cause, and like other types of thrombocytopenia, may involve bleeding into the skin to produce purpura. In most cases of child ITP, the child responds to treatment with steroid drugs.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have chronic idiopathic thrombocytopenic purpura and platelet counts of 40,000 per mm³ or less despite prescribed therapy or recurrent upon withdrawal of treatment.

7. Listing 7.07: Hereditary Telangiectasia (Adults)

Hereditary telangiectasia is a disorder associated with a tendency to form abnormal blood vessels that can affect any organ or other living tissue. The danger of this disorder is that life-threatening bleeding may occur, such as hemorrhaging in the lungs, intestine or brain. The severity of bleeding episodes is established for disability purposes by the need of transfusion of blood. Transfusion could be either whole blood or packed red blood cells.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have hereditary telangiectasia with bleeding requiring transfusion at least three times during the five months before your disability determination.

b. Residual Functional Capacity

Your RFC must be evaluated on a case-by-case basis, applying medical judgment to the number of bleeding episodes, their severity and the types of activities associated with the bleeding, as well as the size, location and number of telang-

iectasias. For example, if lifting 20 pounds triggers an episode of bleeding from the intestine, your RFC should not be higher than sedentary work. In general, if you have significant telangiectasia in any major organ, you'll want an RFC for no more than medium work because the increased blood pressure associated with strenuous exertion might cause serious bleeding.

8. Listing 7.08: Hemophilia and Other Coagulation Disorders (Adults)

Coagulation is the ability of the blood to form clots, and is caused by a long complex chain of chemical reactions involving a number of proteins in the blood called coagulation factors. Coagulation factors are made in the liver.

The various types of hemophilia are caused by a deficient production of some type of coagulation factor. For example, hemophilia A is caused by a coagulation factor VIII deficiency, hemophilia B by a factor IX deficiency and hemophilia C by a factor XI deficiency. About 80% of hemophiliacs have hemophilia A, as do most disability applicants.

The treatment for hemophilia is periodic administration of the deficient coagulation factor. Periodic transfusion of the missing coagulation factor to prevent bleeding is not the same as a transfusion to replace blood loss as required by the listing. Transfusions to replace blood loss from bleeding may be either in the form of whole blood or packed red blood cells.

A spontaneous hemorrhage as required by the listing is one in which there is bleeding without any traumatic cause. The listing concerns only the severity of the bleeding itself caused by a coagulation disorder. If your bleeding damages an organ, such as the brain, evaluation would also involve other appropriate listings. Bleeding into a joint space is known as hemarthrosis and can result in severe arthritis and functional loss of a limb.

Hemophilias are not the only type of coagulation disorders that could potentially qualify under this listing. Some coagulation disorders are not caused by a deficiency of a coagulation factor, but by an abnormality of the coagulation system. For example, some hemophiliacs develop excessive amounts of an antibody that acts as an inhibitor to the needed coagulation factor and causes an increased tendency to bleed. Advanced liver disease interferes with the production of coagulation factors and such individuals may have a tendency to bleed excessively, but these cases can be allowed under Listing 5.05 for chronic liver disease (Chapter 20).

The presence of a coagulation disorder must be proven by the measurement of coagulation factors (coagulation factor assay), abnormal coagulation times or other appropriate tests. If you have a coagulation disorder, you would already

have had the needed diagnostic work-up and the SSA will require that information from your treating doctor.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have coagulation defects (hemophilia or a similar disorder) with spontaneous hemorrhage requiring transfusion at least three times during the five months before disability determination.

b. Residual Functional Capacity

Evaluation must be done on an individual basis, taking into account not only bleeding but any other permanent damage done to the body by previous episodes of bleeding. For example, bleeding into a knee joint can result in arthritis that markedly limits ability to stand and walk, especially with repeated episodes of bleeding into the joint. Inability to stand and walk at least six to eight hours daily limits an RFC to no more than sedentary work with further limitation on the use of leg controls. Even if you have the strength to do heavy work, to do so is probably too dangerous: it is difficult to do heavy lifting or work around heavy equipment without occasional physical trauma. What might ordinarily result in only a bruise in a normal person can result in severe bleeding with a coagulation disorder like hemophilia. This is particularly true for blows to the head. Even if a particular job is not heavy work, you should not be performing it if there is significant danger of physical trauma such as falling or being cut.

9. Listing 107.08: Inherited Coagulation Disorders (Children)

The comments under Listing 7.08 apply here.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have an inherited coagulation disorder. Additionally, the child's condition must satisfy ① or ②, below.

① Repeated spontaneous or inappropriate bleeding.

Inappropriate bleeding means bleeding starting as a result of trauma (such as a mild bump or fall) that would not cause bleeding in a normal person or that results in excessive bleeding. The SSA does not define repeated. Medical judgment must be applied case by case, taking into consideration the frequency and severity of bleeding episodes and whether severity is likely to fulfill the 12-month requirement for disability.

② Bleeding into a joint with resulting joint deformity.

Marked deformities would obviously qualify—such as fixation of the joint in a particular position (ankylosis), destruction of the joint, determined by x-ray, or instability of the joint requiring a brace to walk; however, this listing does not say that a marked joint deformity is necessary. It is reasonable to expect that significant—more than slight—joint damage is required to produce a deformity, and that the child would have some difficulty walking. But the SSA should not assert that the child needs a brace or crutch to walk or that the joint be unable to move—the listing does not specify that degree of required severity.

10. Listing 7.09: Polycythemia Vera (Adults)

Polycythemia vera is a serious disease of the bone marrow resulting in abnormally increased numbers of red blood cells, white blood cells, platelets and blood volume. Also, the patient usually has an enlarged spleen.

Because of the increased number of red blood cells, the hematocrit is abnormally high in polycythemia. This isn't much of a problem until the hematocrit reaches about 60%. At that point the viscosity (self-stickiness) of the blood greatly increases and you are in danger of blood vessel blockage somewhere in the body. If blood vessel blockage happened in the brain, for example, you'd suffer a stroke. Similarly, you might experience a heart attack from blockage of a coronary artery.

Even without blockage of a blood vessel, a high red cell count indicated by hematocrits of 60% or more and high blood volume can stress any organ, including the heart and vascular system. Several neurological symptoms can result from abnormal blood circulation through the brain.

The most frequent treatment for polycythemia vera is phlebotomy. Such blood removal keeps the blood volume and hematocrit from getting too high. If the red cell count and blood volume can be kept in normal ranges, symptoms and dangers are minimized. Measurement of the hematocrit is an easy way to monitor the need for phlebotomy.

If phlebotomy fails, treatments that intentionally damage part of the bone marrow so it won't produce excessive blood cells may be administered. Radioactive phosphorus has been used for this purpose, but carries an increased risk of cancer.

Just having polycythemia vera does not result in a granting of disability. The severity of the impairment depends on the kind of damage done to the body. The diagnosis of polycythemia vera requires measurements of the blood volume. These measurements are exacting and require the use of radioactive substances (radionuclides) to tag red blood cells

and plasma. Such tests should have been done by your treating doctor if you've been diagnosed with polycythemia vera.

Far less serious than polycythemia vera is the secondary polycythemia of people with increased numbers of red cells in the body's attempt to improve the oxygenation of tissues. Secondary polycythemia is frequently seen in people with advanced lung disease; it is not considered under this listing, however, and is much more common than polycythemia vera. Do not confuse the two disorders.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have polycythemia vera with erythrocytosis, splenomegaly and leukocytosis or thrombocytosis. The SSA will evaluate any resulting impairment under the listings dealing with the affected body system.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account the response to treatment and the nature and extent of major organ damage. Even without organ damage, the presence of increased blood volume (indicated by a high hematocrit, especially of 60% or more) can produce headaches, weakness and easy fatigability. It is important that you have your symptoms clearly documented, especially regarding your functional limitations and preferably in your treating doctor's medical records.

11. Listing 7.10: Myelofibrosis (Adults)

Myelofibrosis (myeloproliferative syndrome) means a change of normal bone marrow into fibrotic tissue. Normally, bone marrow consists of large numbers of cells—red cells, white cells, plasma cells and platelets. The bone marrow supplies the cells for the blood stream. Myelofibrosis can be caused by toxic substances, cancer, malnutrition, infection, radiation or may be of unknown cause. Fortunately, myelofibrosis is not a common disorder.

The three most serious complications of myelofibrosis are:

- anemia secondary to the loss of red blood cells
- recurrent bacterial infections secondary to decreased white blood cells, and
- bone pain created by a bone abnormality called osteosclerosis.

Myelofibrosis must be diagnosed by a bone marrow biopsy. Your treating doctor must perform the biopsy; the SSA will not order this test because it is invasive.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have ①, ② or ③, below,

- ① Chronic anemia. Evaluate according to Listing 7.02.
- ② Documented recurrent systemic bacterial infections occurring at least three times during the five months before disability determination.
- ③ Severe and intractable bone pain with x-ray evidence of osteosclerosis.

b. Residual Functional Capacity

No absolute rules can be given. Early myelofibrosis might produce no symptoms or limitations, but at a severe stage you could be restricted to as low as sedentary work. Your symptoms and resulting functional limitations need to be documented in your treating doctor's medical records. If you have anemia, see the RFC discussion under Listing 7.02.

12. Listing 7.11: Acute Leukemia (Including T-cell Lymphoblastic Lymphoma) (Adults)

Leukemia is a form of cancer affecting the blood-forming organ (bone marrow). The white blood cell level rises very high.

The most dangerous forms of leukemia are the acute forms, such as acute myelocytic leukemia, acute lymphocytic leukemia and acute monocytic leukemia. Acute refers to leukemias that are more aggressive and generally have a poorer outcome than chronic leukemias. Acute leukemia may be accompanied by lymph node enlargement, severe fatigue, anemia, decrease in platelets with bleeding, invasion of body organs with large numbers of cancerous white cells and infection. Infection is a frequent cause of death. Untreated acute leukemias are fatal in several months. With treatment, you may live several years or even be cured.

To prove the initial existence of leukemia, the SSA requires a bone marrow biopsy or bone marrow aspiration. Examination of the peripheral (circulating) blood cannot be used for the initial diagnosis of leukemia. The SSA does accept the examination of the peripheral blood or cerebrospinal fluid to demonstrate recurrent leukemia. Copies of all laboratory reports, including pathology reports of bone marrow biopsy and aspiration results, must be available to the SSA to demonstrate any type of leukemia.

You can be without any evidence of leukemia at the time of disability determination and still qualify under the listing as long as the determination is within two and one-half years of the date of a valid diagnosis. The reason the SSA automatically gives benefits two and one-half years after

diagnosis is the poor prognosis for leukemia. Even with an initial remission, the probability of recurrence and death is high during the first two and one-half years after diagnosis. This is not to say you should give up hope if you have leukemia—cures do happen and new treatments are continually being researched.

After two and one-half years from the initial diagnosis, you no longer automatically qualify, and must be evaluated on the basis of what residual impairment is present. Although not stated by the listing, it would seem medically reasonable that recurrent acute leukemia after a period of complete remission should be treated like a new initial diagnosis. This would be consistent with the way child leukemia is evaluated (107.11), and with how other adult cancers are treated. Furthermore, recurrence should entitle you to another two and one-half years' minimum of disability, because such relapses are less likely to be controlled than the initial onset of the disease.

a. Listing Level Severity

The SSA will automatically consider you to be under a disability for two and one-half years from the time of initial diagnosis of acute leukemia.

b. Residual Functional Capacity

You may become asymptomatic once your disease is controlled. However, you may have some residual impairment from a complication of the leukemia or toxicity of chemotherapy that would require RFC restriction after two and one-half years, even though the leukemia itself is controlled. For example, you might suffer some weakness or paralysis of an arm or leg as a result of a stroke or continuing easy fatigability from damage to the heart. Each case must be evaluated individually.

13. Listing 107.11: Acute Leukemia (Including T-cell Lymphoblastic Lymphoma) (Children)

The comments under Listing 7.11 apply here.

a. Listing Level Severity

Instead of evaluating the severity of the child's condition, the SSA will take one of the two approaches described in ① and ②, below, depending on which is appropriate.

- ① Consider the child to be under a disability for two and one-half years from the time of initial diagnosis.
- ② Consider the child to be under a disability for two and one-half years from the time of recurrence of active disease.

14. Listing 7.12: Chronic Leukemia (Adults)

The most common forms of chronic leukemia include chronic myelocytic leukemia (CML) and chronic lymphocytic leukemia (CLL). Other types of chronic leukemia are prolymphocytic leukemia (PLL), hairy cell leukemia and T-cell chronic lymphocytic leukemia (T-cell CLL).

A special SSA medical policy applies to people with CML that is not evident from this listing. Claimants with CML tend to relapse and die even if they initially respond well with treatment. The median survival rate is three years. Their relapse is in the form of what is called a blast crisis or blastic transformation, in which the abnormal cells of CML are replaced with the even more cancerous cells of acute myelocytic leukemia (AML). The usual outcome of a blast crisis is death, most often from infection. When CML turns into AML, the case could be evaluated under Listing 7.11 for acute leukemia.

About 25% of patients with CML have a blast crisis in the first year after diagnosis. Therefore, the SSA grants all cases of CML, even before they have turned into AML, under Listing 13.27 that deals with leukemia (Chapter 28). The one exception is if you have had a bone marrow transplantation. In that case, a complete cure is more likely and your claim would be evaluated under Listing 7.17, which deals with bone marrow transplantation. You would qualify for one year of benefits from the date of transplantation, and then be re-evaluated.

Two other forms of chronic leukemia should be treated under the same special policy as CML, although the SSA's policy does not refer to them. Both prolymphocytic leukemia and T-cell chronic lymphocytic leukemia have as poor a prognosis as CML.

If all of this sounds confusing, just remember these two basic facts:

- CML, PLL and T-cell CLL should all be allowed as equivalent severity to Listing 13.27.
- Any chronic leukemia that has changed into an acute leukemia should be allowed under Listing 7.11.

If your leukemia isn't CML, PLL, T-cell CLL or a chronic leukemia that has changed into an acute leukemia, your disability evaluation will be based on how sick you are, how well you respond to treatment and your complications. To prove the initial existence of leukemia, the SSA requires a bone marrow biopsy or bone marrow aspiration. Examination of the peripheral (circulating) blood cannot be used for the initial diagnosis of leukemia. The SSA does accept the examination of the peripheral blood or cerebrospinal fluid to demonstrate recurrent leukemia. Copies of all laboratory reports, including pathology reports of bone marrow

biopsy and aspiration results, must be available to the SSA to demonstrate any type of leukemia.

Although this Listing deals with chronic leukemia, it also refers to possible evaluation under Listing 13.06A (Chapter 28) which concerns lymphoma forms of cancer. This is because CLL and lymphomas both involve abnormal lymphocytes; in some cases, the two conditions overlap.

Generally speaking, CLL is often a slowly progressive leukemia in which patients have no symptoms, nor is treatment always necessary at the time of diagnosis. CLL occurs almost exclusively in older people and is often compatible with a life span of ten to 20 years. If you have problems as a result of CLL, this listing offers guidance to the other listings that would be relevant. If you are one of the 2% of people with CLL who have the more dangerous T-cell CLL, your case should be granted as discussed above.

Hairy cell leukemia frequently responds to treatment with long-lasting remissions. About 10% of people with this disorder remain asymptomatic for many years without needing treatment. Infections and an enlarged spleen can be a particular problem during treatment. Like CLL, hairy cell leukemia is not a disorder that automatically means a granting of benefits; each case must be evaluated individually.

a. Listing Level Severity

The SSA will evaluate your impairment according to the criteria in Listing 7.02 (anemia), 7.06 (low platelet count), 7.10[Ⓐ] (recurrent bacterial infections), 7.11 (acute leukemia), 7.17 (bone marrow transplantation) or 13.06[Ⓐ] (lymphoma).

b. Residual Functional Capacity

The comments about RFC under Listing 7.11 apply here.

15. Listing 7.13: Lymphomas (Adults)

Lymphomas are cancers of the lymph nodes and spleen that produce abnormal lymphocytes. Lymphomas can invade other organs of the body, including the brain and bone marrow. Lymphomas usually respond well to treatment, especially Hodgkin's lymphoma. Non-Hodgkin's lymphoma consists of more than one specific type, and is generally a more serious cancer than Hodgkin's lymphoma.

No actual evaluation is done under this listing. Evaluation is done under adult cancer Listing 13.06[Ⓐ]. Copies of pathology reports of bone marrow biopsy and aspiration results must be available to the SSA to demonstrate any type of lymphoma.

a. Listing Level Severity

The SSA will evaluate your impairment under the criteria in Listing 13.06[Ⓐ].

b. Residual Functional Capacity

If anemia is a problem, see the discussion of RFC under Listing 7.02. If you have just started treatment, however, the SSA will not expect symptoms related to chemotherapy such as anemia, weakness and nausea to last the required 12 months—chemotherapy is only given for several months. Radiation therapy can also produce acute symptoms, but they also usually improve after treatment.

But both chemotherapy and radiation can have long-term side effects. For example, radiation can cause fibrosis of the lungs with resultant cough and shortness of breath—a condition known as radiation pneumonitis. Some of the drugs used to treat lymphoma can damage the lungs and heart. Depending on the drugs given and locations of radiation, the kidneys and thyroid gland can be damaged. There are too many possibilities to make broad rules about RFC that would apply to everyone. Cases are evaluated individually. When chronic weakness and easy fatigability are a problem, make sure that the SSA has good examples of what you can and cannot do—such as limits on how much you can lift and exactly what activities are limited. Ask your treating doctor to record your limitations in your medical record, especially if your symptoms persist well beyond the time required for your treatment.

16. Listing 7.14: Macroglobulinemia or Heavy Chain Disease (Adults)

Macroglobulinemia is a fairly rare disease characterized by abnormally high levels of the antibody known as immunoglobulin M. You may suffer weakness, headaches, weight loss and fatigue due to the increased self-stickiness (viscosity) of blood which interferes with circulation. You may also have visual problems from bleeding in the eyes. Infections are more frequent than normal.

Heavy chain disease refers to various disorders in which you have abnormally high levels of fragments of antibodies. Fevers, infections and anemia are common.

Both macroglobulinemia and heavy chain disease must be diagnosed with serum or urine protein electrophoresis or immunoelectrophoresis. Your treating doctor would have done the necessary tests; the SSA will need the results.

Removal of excessive antibodies from the blood by plasmapheresis is the method of treatment of these disorders. Chemotherapy may also be used. Both macroglobulinemia and

heavy chain disease are types of plasma cell dyscrasia because they involve abnormal antibody production by plasma cells.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have macroglobulinemia or heavy chain disease, confirmed by serum or urine protein electrophoresis or immunoelectrophoresis. The SSA will evaluate your impairment under the affected body system, such as listings or under 7.02, 7.06 or 7.08.

b. Residual Functional Capacity

See RFC discussion related to whatever listing(s) is used for evaluation. If your disorder is not at listing-level severity but still significantly limiting, you are most likely to have symptoms and limitations related to anemia as described in the RFC discussion of Listing 7.02.

17. Listing 7.15: Granulocytopenia (Adults)

Granulocytopenia refers to low levels of certain types of white blood cells called granulocytes, especially neutrophils. Neutrophils are important in fighting infection, and a low neutrophil blood count is specifically referred to as neutropenia. Granulocytopenia might be caused by infection, toxic substances or drugs, or be of unknown cause.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have chronic granulocytopenia (due to any cause). Additionally, you must satisfy ④ and ⑤, below.

- ④ Absolute neutrophil counts repeatedly below 1,000 cells/cubic millimeter of blood (1,000 neutrophils per mm^3). This number is significant, because when the neutrophil count falls that low, you are in great danger of life-threatening systemic infections. Although neutrophils are a type of white blood cell (WBC), the neutrophil count should not be confused with the total white blood cell count. If the number of neutrophils in laboratory reports are expressed as a percentage of the total white cell count, the absolute neutrophil count is simply that percentage multiplied by the total white cell count. For example, if your total WBC count is 5,000 per mm^3 and your neutrophil count is 10% of the total, then your absolute neutrophil count is 500 per mm^3 . “Absolute” merely emphasizes that an actual count of neutrophil cells is considered, rather than neutrophils as a percentage of the total white cells. Knowing this, it is easy for

you to determine your neutrophil count by obtaining your laboratory work from your hospital or treating doctor. The absolute neutrophil count is easily done on a blood sample.

- ⑤ Documented recurrent systemic bacterial infections occurring at least three times during the five months before disability determination. Such systemic infections would require treatment in a hospital with intravenous antibiotics. Cultures of blood that show the presence of bacteria are irrefutable evidence of systemic infection. Such blood cultures would be standard practice to treat systemic bacterial infection, so that information should be available to the SSA.

b. Residual Functional Capacity

Cases must be evaluated on an individual basis, taking into account the effects of any residual impairment including weakness, fatigue and side effects of treatment. During any time you are not suffering the effects of infection or treatment, you might not have any limitations, given that granulocytopenia does not, in itself, produce symptoms. It is quite possible, however, to have a granulocytopenia in which there is also associated anemia. If so, such anemia would be evaluated under Listing 7.02 and the RFC discussion under that listing would also apply here.

18. Listing 7.16: Myeloma (Adults)

Myeloma is a disease in which plasma cells are increased, and is most common after age 40. Plasma cells are manufactured in the bone marrow and are involved in the production of antibodies. In normal bone marrow, only a few percent of the cells are plasma cells; they are increased in myeloma. Plasma cells are not normally seen in the peripheral blood, but may be present in myeloma. Myeloma is commonly referred to as multiple myeloma.

Your treating doctor would have done the appropriate diagnostic testing before you apply for disability. Your bone marrow biopsy would show increased numbers of plasma cells—10% or more. Electrophoresis using a blood or urine sample would show increased amounts of antibody produced by the increased numbers of plasma cells. X-rays would show bone lesions.

The increased numbers of plasma cells in myeloma are most likely to produce excessive amounts of the antibody known as immunoglobulin G (IgG) in the serum. Immunoglobulin A (IgA) is the second most commonly produced antibody. Electrophoresis may be done on urine samples to detect abnormal antibody fragments produced by myeloma.

Such antibody fragments in the urine are known as Bence Jones proteins, but they are not always present.

Weakness, loss of appetite and weight loss are early findings with myeloma. As the disease progresses, you may develop anemia and increasing numbers of infections.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have myeloma (confirmed by appropriate serum or urine protein electrophoresis and bone marrow findings). Additionally, you must satisfy ①, ②, ③ or ④, below.

- ① X-ray evidence of bone involvement with severe bone pain despite treatment (intractable bone pain)—that is, the severe pain resulting from bone lesions caused by plasma cell tumors. Bone lesions can occur anywhere in the skeleton and may be many or few. Weak bone may fracture in abnormal areas, but this is not a requirement of the listing. If you have persistent bone pain, even with treatment, this fact should be documented in your medical records. Severe means more than moderate, and it is expected that such pain and medication used to treat it would result in marked restriction of your daily activities.
- ② Evidence of kidney disease that satisfies the criteria of Listing 6.02.
- ③ Hypercalcemia, with serum calcium levels persistently greater than 11 mg. per deciliter (11 mg/dl) for at least one month despite prescribed therapy.
- ④ Plasma cells in the peripheral blood of at least 100 cells/cubic millimeter (100 per mm^3). Large numbers of plasma cells entering the circulating blood outside of the marrow indicates very severe and uncontrolled disease.

b. Residual Functional Capacity

Cases must be evaluated individually, taking into account the effects of any residual impairment including anemia, kidney failure, bone pain or fractures, weakness, fatigue and side effects of chemotherapy. If you have anemia, see the RFC comments under Listing 7.02. Even if you don't

have severe bone pain, you could nevertheless have bone lesions with lesser pain that limit the amount of weight you can lift. Bone lesions in the spine can lead to spinal fractures and even damage to the spinal cord. If you have spinal lesions—even if they don't cause severe pain—you probably shouldn't have an RFC for more than light work. A large lesion in the spine should restrict you to no more than sedentary work, even if it is not painful enough to qualify under the listing.

19. Listing 7.17: Bone Marrow Transplant (Adults)

Bone marrow transplants are sometimes necessary to treat myelofibrosis and other causes of aplastic anemia that result in loss of bone marrow. Chronic leukemias or other blood-element cancers (hematologic malignancies) that destroy the bone marrow may also require a transplant. The SSA has no bone marrow transplant listing for children, but a child who has a transplant can be considered under this listing. Even if you do very well after a marrow transplant, you are still entitled to the full year of disability. Acute leukemia and T-cell lymphoblastic lymphoma are excluded because they are a basis for disability under Listing 7.11 for a longer period of time than permitted under this listing. Also see the discussion of chronic leukemia under Listing 7.12.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have aplastic anemias or hematologic malignancies (excluding acute leukemia), with bone marrow transplantation. The SSA will consider you to be under a disability for 12 months following transplantation. Thereafter, you will be evaluated according to the type of impairment remaining.

b. Residual Functional Capacity

See discussion of RFC under whatever listings are used to evaluate residual impairment after transplantation. ■

Chapter 23

Skin Diseases

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at nlm.nih.gov/medlineplus.

Acne. Disorder of pilosebaceous glands that can produce comedones, pustules and pus-filled cysts and inflamed nodules.

Actinic keratosis. Scaly skin lesion resulting from excessive exposure to sunlight or other forms of ultraviolet (UV) light. Actinic keratoses are not cancerous and their early stages can easily be removed with liquid nitrogen.

Acute. Limited in duration.

Allergic rhinitis. Allergic condition involving the mucosa of the nose, resulting in itching and congestion; hayfever.

Atopic dermatitis. A common chronic, itching, inflammatory, skin disorder usually associated with a personal or family history of allergic disorders like asthma or allergic rhinitis. Atopic dermatitis may result in eczema. It can occur in infants, children and adults.

Axilla. Armpit.

Basal cell carcinoma (BCC). A form of cancer, strongly associated with exposure to excess sunlight or other forms of ultraviolet (UV) light. BCC rarely spreads to other organs and if caught early can usually be controlled.

Blister. An elevation of the epidermis that contains fluid. A blister will run out if punctured, and the blister will collapse.

Bulla. A blister more than 0.5 centimeter (1/5 inch) in diameter.

Bullous pemphigoid. A pemphigus-like disorder, usually affecting the elderly over 60 years of age. Also known as *parapemphigus*.

Chronic. Persistent.

Collodion. A liquid chemical applied to the skin that dries to a transparent film and is used to cover small wounds or hold dressings or medications on the skin.

Comedo (pl. comedones). A noninflamed lesion of acne, consisting of a plug of sebum, bacteria and keratin (proteins found in the epidermis, hair and nails) in a pilosebaceous gland follicle. A closed comedo is associated with a narrow or closed opening into the follicle and is also known as a white-head or milium. An open comedo is associated with a wide opening into the follicle so that the plug is visible and is commonly known as a blackhead.

Congenital. Dating from the time of birth.

Contracture. Condition in which a limb strongly resists movement from a fixed abnormal position as a result of fibrosis or scarring of ligaments, tendons, muscles or other soft tissues around joints. Contractures of limbs in a bent position are the most common and known as "flexion contractures."

Crusting. Dried body fluids on the skin. The fluids can be blood, serum or purulent material resulting from bacterial infection. Blood tends to form brownish or reddish crusts.

Serum tends to form yellow crusts. Purulent material tends to form yellow-green crusts.

Dermatitis. Any inflammatory condition of the skin.

Dermatitis herpetiformis. Skin disorder producing wheals, red papules or small blisters and almost always associated with severe itching.

Dyshidrosis. A disorder of unknown cause that involves formation of small, clear, itching blisters, especially along the sides of the fingers. Also known as *pompholyx*, *dyshidrotic eczema* and *dyshidrotic eczematous dermatitis*.

Eczema. General word for a type of itchy skin inflammation. Erythema develops in the area of skin involved as a result of inflammation, followed by oozing of clear fluid that tends to produce crusting (dried body fluids on the skin). Small blisters are present (vesiculation) and there may also be scaling and thickening of the skin in advanced cases. One common cause of eczema is an allergic reaction of the skin to some irritant and is known as *atopic dermatitis*.

Epidermis. The outer layer of the skin; contains no blood vessels. Epidermal cells normally fall off or rub off from friction, so that the epidermal layer of skin is replaced about every 27 days.

Erythema. Redness of the skin caused by increased blood flow in the small capillary blood vessels. Erythema often accompanies inflammation, because inflammation is associated with the release of substances that dilate blood vessels and increase blood flow.

Erythema multiforme. Any of several different types of inflammatory disorder associated with the formation of blisters and red papules surrounded by rings to make a characteristic lesion that looks like a target.

Erythroderma. Redness of the skin, usually in reference to a widespread condition.

Exfoliative dermatitis. Widespread erythema and scaling of the skin, sometimes accompanied by itching.

Follicle (hair). The depressed, pouch-like indentation around a hair shaft.

Folliculitis. Inflammation of hair follicles, resulting from bacterial infection and associated with the formation of pustules.

Fungating. Description of lesions that appear as fungus-like growths.

Groin. The area between the thigh and the abdomen.

Hydradenitis suppurative. A disorder involving inflammation and destruction of sweat gland ducts, followed by secondary bacterial infection.

Ichthyosis. A group of skin disorders whose principle feature is scaliness of the skin.

Impetigo. A contagious skin infection caused by staphylococcal or streptococcal bacteria most often seen in children. Small blisters break to form crusts of dried pus. Itching may or

Definitions (continued)

may not be present. Impetigo is associated with poor hygiene and living in crowded conditions.

Lesion. Abnormality.

Macule. A flat area that is different in color from normal skin. A skin lesion that is raised or depressed by any amount is not a macule.

Malignant melanoma. A highly cancerous and dangerous skin tumor that can spread through the body. Once spread to other organs occurs, the prognosis is grave.

Mole. A small, benign skin growth that is common and may be flat or raised. The color is usually brownish to black, though they may also be skin-colored. The medical term for a mole is melanocytic nevocellular nevus. Nevi do not cause any symptoms. Moles can sometime be confused with malignant melanoma, a highly cancerous and dangerous skin tumor that can spread through the body.

Mycotic infections. Fungal infections.

Nevus. Any skin lesion present at birth, of which there are many possible types. Popularly known as a birthmark.

Nodule. A skin lesion that is roundish in shape, solid, can be felt with the fingers, extends down into the dermis and may even involve the subcutaneous tissues beneath the skin.

Papule. A solid skin lesion that is less than 0.5 centimeter in diameter, elevated above the skin and does not extend as deeply into the skin as a nodule.

Parapemphigus. See *bullous pemphigoid*.

Pemphigoid. See *bullous pemphigoid*.

Pemphigus. A general term that includes a number of related skin disorders associated with the formation of large skin blisters (bullae).

Perineum. Area around the genitals and anus.

Pilosebaceous gland. A skin gland that has both a hair follicle and an associated sebum gland.

Plaque. A solid skin lesion that is a half centimeter in diameter or more, elevated above the skin only slightly compared to its large surface area, tends to be flat on top and does not extend deeply into the skin. Also less technically known as a patch.

Pruritus. Itching.

Psoriasis. A chronic hereditary skin disorder usually characterized by white scaly papules and plaques.

Pus. Product of infection, consisting of a liquid component plus white blood cells. Pus may be a variety of colors.

Pustule. An elevated skin lesion containing pus. Pustules result from infection and may be a yellow, brownish, white or greenish color.

Remission. Improvement in a disorder.

Scaling. Shedding of outer skin layers; results from an abnormally increased rate of growth of the cells in the epidermis. Psoriasis is a common skin disorder associated with scaling of skin. Also known as *desquamation*.

Seborrheic keratosis. A benign, rarely symptomatic, skin tumor whose significance is mostly cosmetic. Seborrheic keratoses are common in older adults and usually can be easily removed. They can be brown, black or even skin-colored. A seborrheic keratosis can sometimes be confused with malignant melanoma, a highly cancerous and dangerous skin tumor that can spread through the body.

Sebum. The oily liquid produced by the sebaceous glands of the skin.

Squamous cell carcinoma (SCC) of skin. A form of cancer, strongly associated with exposure to excess sunlight or other forms of ultraviolet (UV) light. SCC rarely spreads to other organs and if caught early can usually be controlled.

Suppurative. Producing pus.

Systemic. Affecting the whole body.

Ulcer. A defect in the skin that involves loss of the epidermis, as well as the top part of the dermis. Many disorders may cause ulcers, including loss of arterial blood supply to an area of skin, poor venous blood circulation, bacterial infections, viral infections, parasitic infections and diabetes.

Vesicle. A blister less than one-half centimeter in diameter.

Wheal. A solid elevated skin lesion that tends to have rounded edges and a flat top. Wheals are caused by excess watery fluid in the skin area concerned and may change in size and shape as this fluid shifts around a little. Wheals usually disappear in a few hours. They are not blisters. In wheals, the fluid is mixed in between cells and is deeper than a blister. The difference between wheals and blisters is usually obvious on examination. Disorders that may be associated with wheals are dermatitis herpetiformis and allergic reactions.

A. General Information

Skin disorders may be acute or chronic and cover a wide range of severity. Disorders that involve the hands and feet or large areas of skin are the ones likely to result in functional impairment. Skin lesions must be present long enough despite treatment to be expected to last 12 months. Some skin disorders require potent drugs for long periods of time; the side effects of medications must be considered in the disability evaluation.

There are many types of skin diseases; the SSA Listings cover the diseases most likely to be disabling. Skin cancers like squamous cell carcinoma, melanoma and basal cell carcinomas are discussed in the cancer listings (Chapter 28). Common skin lesions like impetigo, actinic keratosis, seborrheic keratosis and moles are never disabling, would not result in functional limitations and are not discussed.

While some skin disorders involve only the skin, others may be associated with systemic diseases. For example, chronic venous insufficiency, diabetes mellitus and arterial vascular disease can result in severe ulceration of the skin. Scleroderma causes a hardening of the skin with loss of flexibility and systemic lupus erythematosus can affect the skin. A systemic disorder with skin lesions must be evaluated under the listings appropriate to the disorder, with consideration for the effect on the skin. Skin lesions associated with loss of motion, such as burn scars resulting in contractures, should be evaluated under the musculoskeletal listings (Chapter 16).

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. There are no child listings for skin disorders. However, if a child has such a condition, it can also be evaluated under these listings.

1. Listing 8.02: Exfoliative Dermatitis, Ichthyosis, Ichthyosiform Erythroderma (Adults)

This listing deals with disorders that cause severe inflammation and scaling of the skin.

Exfoliative dermatitis is a general term for a condition of widespread erythema and scaling of the skin, sometimes accompanied by itching. This skin disorder may arise along with various other skin disorders like atopic dermatitis, psoriasis, cancer or as a drug reaction. Exfoliative dermatitis is a serious, potentially fatal, affliction that usually requires hospitalization and treatment with steroid drugs.

Ichthyosis refers to several skin disorders, usually hereditary, whose principle feature is a scaly appearance to the skin. Not all cases of ichthyosis are considered severe disorders. For example, ichthyosis vulgaris is a common skin condition of modest scaliness that spares the face and functional areas on the feet and hands. X-linked ichthyosis is found only in men and results in a dirty brownish appearance to the skin. It also spares the functional areas of the hands and feet and its most limiting feature is cosmetic.

Ichthyosiform erythroderma is the most serious of the ichthyosis disorders and affects both sexes. Fortunately, it is a rare disease. At birth, the infant is covered with a membrane that resembles collodion; hence the name "collodion baby." With survival, the person faces a lifetime of disease—large scales widely affecting skin surfaces, including the palms and soles of the feet, which may include painful fissures in the skin. Inability to sweat puts the person at risk of over-heating during strenuous exercise, especially in hot weather.

Another variant is bullous congenital ichthyosiform erythroderma. This blistering disorder is characterized by erythroderma with thick scales over most of the skin surface.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have exfoliative dermatitis, ichthyosis or ichthyosiform erythroderma with extensive lesions not responding to prescribed treatment. Extensive is not defined regarding the amount of skin area involved. Medical judgment is applied; greater weight is given when the hands and feet are involved. The palms of the hands and soles of the feet are particularly important because of the pressure against the skin during physical work. The listing does not require involvement of the hands or feet, however.

b. Residual Functional Capacity

RFCs must be based on medical judgment applied case by case, but areas of skin involved should not be exposed to environmental conditions that make them worse. For example, skin lesions affecting the hands should not be exposed to excessive amounts of water and certainly not to chemicals or solvents. Involvement of the feet should be carefully considered regarding ability to stand and walk. Inability to stand and walk for six to eight hours daily would automatically reduce your RFC to sedentary work, even if your hands are strong and unaffected. The cosmetic effects of skin disorders might affect a narrow range of jobs, such as modeling, but would have little practical effect on your ability to perform most jobs.

2. Listing 8.03: Pemphigus, Erythema Multiforme Bullosum, Bullous Pemphigoid, Dermatitis Herpetiformis (Adults)

This listing deals with disorders that cause severe blistering of the skin.

Pemphigus is a general term that includes a number of related skin disorders associated with the formation of large skin blisters. The various forms of pemphigus are autoimmune disorders in which the patient's own immune system attacks the skin with blister formation.

Pemphigus vulgaris is the most serious form of pemphigus and afflicts middle-aged men and women. In pemphigus vulgaris, blistering starts in the mouth, followed in some months by blistering of the skin. The blisters don't itch, but rupture of the blisters can cause severe pain. Involvement of the mouth and upper esophagus can effect your ability to eat properly with resultant malnutrition. Unlike many skin disorders, pemphigus can be fatal. This outcome will occur without treatment with steroid and other drugs that suppress the immune system.

There are variants of pemphigus vulgaris. Pemphigus foliaceus is a form of pemphigus vulgaris that rarely causes blister formation, but is still a serious disorder than can involve inflammation of the entire skin surface. Other cases may be limited to the scalp, abdomen, face or upper chest. Brazilian pemphigus is similar to pemphigus vulgaris. Pemphigus vegetans is usually confined to areas of skin that come into contact with each other, as well as the neck, scalp and around the mouth. Pemphigus vegetans can turn into the pemphigus vulgaris or vice versa. Pemphigus erythematosus can involve the face, chest and area between the shoulder blades; it is similar to pemphigus foliaceus. A drug-induced pemphigus usually resolves with stopping the offending drug.

Bullous pemphigoid is a pemphigus-like disorder, usually affecting people over 60 years of age. Like pemphigus, it is an autoimmune disease and is associated with the formation of large blisters. Blisters may be found on the mucous membranes of the mouth; mucous membranes in the vagina and anus may be sites for blister formation. However, blisters are less painful and less delicate than in pemphigus vulgaris, which is generally a more serious disease.

Erythema multiforme is a disorder associated with the formation of blisters and red papules surrounded by rings to make a characteristic lesion that looks like a target. The mucous membranes of the mouth and lips are involved in 99% of cases. The top and palms of the hands, soles of the feet, elbows, knees, penis and outer female genitalia may also be involved. The disorder can also affect the throat, voice box, trachea and eyes. In serious cases, the kidney can also be involved, as well as the membranes covering the brain.

Erythema multiforme can be related to other diseases such as prior herpes simplex infection or drugs, but more than half the cases are of unknown cause. Erythema multiforme minor is related to prior herpes infection and is a disorder of lesser severity with no involvement of mucous membranes, eyes or other internal organs. It can be controlled with treatment of herpes.

Erythema multiforme major is the more serious form, with its mucous membrane and multi-organ involvement as noted above, along with formation of large blisters. It is also known as erythema multiforme bullosum. It often occurs as a drug reaction and can be fatal.

Dermatitis herpetiformis is a skin disorder producing wheals, red papules and small blisters, and is almost always associated with severe itching. Lesions are most likely on the elbows and knees, but any skin area could be involved. It is most common in males 30–40 years old. This immune disorder is associated with abnormalities of the small intestine. Ten to 20 percent of cases may have malabsorption of nutrients from the small intestine, in which case the digestive system listings should also be considered (Chapter 20). Symptoms are most often confined to the skin, however.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have pemphigus, erythema multiforme bullosum, bullous pemphigoid or dermatitis herpetiformis with extensive lesions not responding to prescribed treatment. Extensive is not defined regarding the amount of skin area involved. Medical judgment is applied; greater weight is given when the hands and feet are involved. The palms of the hands and soles of the feet are

particularly important because of the pressure against the skin during physical work. The listing does not require involvement of the hands or feet, however.

3. Listing 8.04: Deep Fungal Infections (Adults)

This listing deals with mycotic infections that cause severe destruction of tissues, such as blastomycosis, coccidioidomycosis and cryptococcosis. Infection with a fungus is less frequent than with bacteria or viruses, and only deeply invasive fungi that affect large areas of skin can qualify. Severe, persistent fungal infections are unusual and most likely to be found in people who suffer from depression of their immune system, such as those with AIDS or who are otherwise weakened and susceptible to infection as a result of chronic diseases.

Skin lesions that appear fungus-like are called fungating. The deep lesions required by this listing extend far beyond the surface layers of the skin and even the tissues beneath the skin. Any sufficiently severe fungal infection can qualify. Treatment of deep fungal infections can be a medical challenge. Not only must you take potent drugs with potential side effects, but also you are likely to have a severe medical disorder that has allowed the fungal infection to occur.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have deep fungal infections with extensive fungating, ulcerating lesions not responding to prescribed treatment. Extensive is not defined regarding the amount of skin area involved. Medical judgment is applied; greater weight is given when the hands and feet are involved. The palms of the hands and soles of the feet are particularly important because of the pressure against the skin during physical work. The listing does not require involvement of the hands or feet, however.

b. Residual Functional Capacity

The discussion of RFC under Listing 8.02 applies here.

4. Listing 8.05: Psoriasis, Atopic Dermatitis, Dyshidrosis (Adults)

The three disorders covered by this listing have little in common medically, but have similar criteria for allowance.

Psoriasis is a chronic hereditary skin disorder usually characterized by white scaly papules and plaques. Inflammation may also be present. It affects about 2% of the population. Lesions are sometimes salmon pink. Psoriasis may occur on any skin surface and is especially common

on the elbows and knees. Scratching makes the condition worse. Many cases of psoriasis do not cause significant functional limitations, but there are exceptions. Some cases of psoriasis can be associated with the development of a very severe form of arthritis known as psoriatic arthritis (Chapter 16).

Atopic dermatitis is a common chronic, itching, inflammatory skin disorder usually associated with a personal or family history of allergic disorders like asthma or allergic rhinitis. Atopic dermatitis may result in eczema. Atopic dermatitis can occur at all ages.

Dyshidrosis is a disorder of unknown cause that involves formation of small, clear, itching blisters, especially along the sides of the fingers. The palms of the hands and the soles of the feet are also involved about 80% of the time. The blisters have a tapioca-like appearance. You may suffer from scaling and redness of the skin with fluids leaking from the blisters. Fissures may develop in the skin, causing severe functional limitation. Dyshidrosis can be chronic or recurrent with remissions. You may suffer from excessive, decreased or normal sweating.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have psoriasis, atopic dermatitis or dyshidrosis that involves extensive lesions that are not responding to prescribed treatment. Additionally, the condition must involve the hands or feet in a way that imposes a marked limitation on your use of the hands or your ability to stand and walk. Extensive is not defined regarding the amount of skin area involved. Medical judgment is applied; greater weight is given when the hands and feet are involved. The palms of the hands and soles of the feet are particularly important because of the pressure against the skin during physical work. The listing does not require involvement of the hands or feet, however.

b. Residual Functional Capacity

The discussion of RFC under Listing 8.02 applies here.

5. Listing 8.06: Hydradenitis Suppurative, Acne Conglobata (Adults)

These disorders involve severe bacterial skin infections that can be associated with inflammation and scarring.

Hydradenitis suppurative is characterized by inflammation and destruction of sweat gland ducts, followed by secondary bacterial infection. The areas of skin most often involved

are the axillae and the groin area. The bacterial infection can lead to pain, abscesses and scarring. Surgery and skin grafting may be necessary, along with treatment with antibiotics. Severity of the disorder varies.

Acne is an inflammatory disorder of pilosebaceous glands. In addition to inflammation and resulting redness, acne involves infection with the formation of pustules, comedones and cysts. The face is most commonly involved, but the neck, chest and back can also be affected. There are many specific forms of acne, the most common being acne vulgaris. Acne conglobata is a very severe form of acne and is more likely to be disabling than common acne.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have hydradenitis suppurativa or acne conglobata with extensive lesions involving the axillae or perineum. The disorder also must not respond to prescribed medical treatment and not be lesions that could be treated adequately with surgery. Extensive is not defined regarding the amount of skin area involved. Medical

judgment is applied; greater weight is given when the hands and feet are involved. The palms of the hands and soles of the feet are particularly important because of the pressure against the skin during physical work. The listing does not require involvement of the hands or feet, however.

b. Residual Functional Capacity

RFCs must be based on medical judgment applied on a case-by-case basis. Areas of skin involved should not be exposed to environmental conditions that make them worse, such as working in hot environments that can cause sweating. Inflamed, infected, pus-draining, painful lesions in the armpits can affect ability to use the arms. Scars from prior infection can also limit use of the arms, such as in the ability to extend the arms overhead. Similar lesions in the perineal area can limit ability to stand and walk because of pain. Inability to walk or stand for six or eight hours daily is important, because it reduces the RFC to no higher than sedentary work. ■

Chapter 24

Hormone Disorders

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Acidosis. Abnormal condition, characterized by an increase in the blood's acidity. See *ketoacidosis*.

Addison's disease. A form of adrenal insufficiency, characterized by a decreased production of cortisol.

Adrenal glands. Hormone-producing glands sitting on top of each kidney. The outer layers of the adrenal glands (cortex) secrete the natural steroid hormone cortisol. The adrenal glands also secrete aldosterone, epinephrine, norepinephrine and normally small amounts of sex hormones.

Adrenal insufficiency. Decreased hormone output by the adrenal glands, usually in reference to decreased secretion of cortisol.

Adrenalectomy. Removal of part or all of an adrenal gland.

Adrenogenital syndrome. A disorder characterized by increased adrenal gland production of hormones that increase male sex characteristics (adrenal androgens). In boys, the effect is the production of early and excessive early (precocious) male sex characteristics; in girls, the effect is the production of both male and female sex characteristics (pseudohemaphroditism).

Aldosterone. Adrenal gland hormone important in maintaining blood pressure and blood volume by causing the kidneys to retain sodium and water. The right amount of aldosterone is important, but excess amounts can lead to high blood pressure. Excess aldosterone production is called hyperaldosteronism and a deficiency of aldosterone is known as hypoaldosteronism.

Androgens. Hormones that induce male sex characteristics.

Antidiuretic hormone. Hormone released from the pituitary gland that causes the kidneys to save body water. Also known as *vasopressin*.

Bone densitometry. Several possible x-ray methods of measuring bone density to determine if there is osteoporosis.

Calcitonin. A hormone secreted from the thyroid gland whose actions decrease blood calcium levels. It has the opposite effect as parathyroid hormone.

Cataract. Degeneration of the lens of the eye so that light cannot easily pass through it. Most cataracts are related to aging, but some date from birth (congenital cataracts) or from the use of medication, such as the chronic use of steroid drugs. Cataracts are sometimes described by doctors as lens opacity.

Congestive heart failure. Failure of the heart as a pump—the heart cannot keep up with pumping out the blood flowing into it. Consequently, the heart is enlarged and there is fluid congestion of organs such as the liver and lungs.

Convulsions. Involuntary contractions of muscles, related to abnormal electrical activity in the brain. Also known as *seizures*.

Corticosteroids. Hormones secreted by the outer layer (cortex) of the adrenal glands. Corticosteroids are divided into glucocorticoids such as cortisol and mineralocorticoids such as aldosterone. Glucocorticoids influence the metabolism of carbohydrates, fats and proteins. Mineralocorticoids are important in maintaining the body's water and electrolyte (especially sodium and potassium) balance. Hormones with sexual activity are usually excluded from the classification as corticosteroids although they are also normally produced in small amounts by the adrenal cortex (see *adrenogenital syndrome*).

Cushing's syndrome. A group of physical abnormalities associated with the effects of glucocorticoid hormones such as cortisol. Cushing's syndrome can be caused either by increased output of cortisol from diseased adrenal glands or by excessive long-term intake of glucocorticoid drugs like prednisone.

Diabetes insipidus. A condition associated with excessive loss of body water through the kidneys as a result of decreased antidiuretic hormone (ADH). ADH is normally secreted by the back part of the pituitary gland (neurohypophysis). Also known as *neurohypophyseal insufficiency* and *neurogenic or central diabetes insipidus*. (Another condition, nephrogenic diabetes insipidus, is not due to lack of ADH, but is caused by kidney disease that makes the kidneys nonresponsive to ADH. Most kidney diseases are potentially capable of causing nephrogenic diabetes insipidus.)

Diabetes mellitus. A disorder of glucose metabolism caused by insufficient insulin; may also involve the cellular resistance to insulin that is present.

Diabetic necrosis. Death of tissue as a result of uncontrolled diabetes.

Dysgenesis. Defective development.

Endocrine. Refers to the hormone system of the body.

Exophthalmometry. Measurement of the amount of exophthalmos, measured with an instrument called an exophthalmometer.

Exophthalmos. A bulging outward of the eyes, a possible complication of hyperthyroidism.

Fasting blood glucose (FBG). Blood glucose measured after at least an overnight fast. In nonpregnant adults FBG should be less than 140 mg/dl. Also called fasting blood sugar (FBS).

Glucose. A simple sugar that is the body's main source of energy.

Goiter. An enlarged thyroid gland sufficient to cause a visible swelling in the front of the neck.

Gonad. Reproductive organ—ovary or testis.

Gonadal dysgenesis. See *Turner's syndrome*.

Heart failure. See *congestive heart failure*.

Hirsutism. Abnormal hairiness—an effect of excessive male sex hormones on children or women.

Definitions (continued)

Hormone. Any of a number of chemicals produced naturally in the body that regulate the activity of glands, organs or cells.

Hypercalcemia. Abnormally high blood calcium. Normal serum calcium is about 8–10 mg/dl.

Hyperglycemia. Abnormally high blood glucose.

Hypernatremia. Abnormally high blood sodium.

Hyperparathyroidism. Disorder in which there is excessive production of parathyroid hormone (PTH).

Hypertension. High blood pressure. Hypertension usually means systemic hypertension, or high blood pressure in the arterial system of the body other than the lungs. Hypertension in adults is defined as any pressure of 140/90 or greater. In children, normal expected blood pressure varies with age.

Hyperthyroidism. Disorder in which there is excessive production of thyroid hormone.

Hypocalcemia. Abnormally low blood calcium. When blood calcium falls to about 7 mg/dl, a life-threatening situation is present.

Hypoglycemia. Abnormally low blood glucose. Hypoglycemia is present with blood glucose levels of less than 50 mg/dl in adult males following a prolonged fast, but in women, children and infants glucose levels may drop below this value without symptoms, and in these instances the diagnosis of hypoglycemia based on blood sugar alone might be inappropriate.

Hypoparathyroidism. Disorder in which there is a deficiency of parathyroid hormone (PTH).

Hypothalamus. An area at the bottom of the brain with a number of functions, including the production of various types of *releasing hormones* that trickle down the pituitary stalk into the pituitary gland and cause it to in turn release other hormones. For example, thyrotropin-releasing hormone (TRH) is made in the hypothalamus and stimulates the pituitary gland to release thyroid stimulating hormone (TSH), which in turn stimulates the thyroid gland in the neck to release thyroid hormone.

Hypothyroidism. Disorder in which there is a deficiency in thyroid hormone. Also known as *myxedema*.

Iatrogenic. Reference to disorders caused by treatment.

Insulin. A pancreatic hormone that circulates in the bloodstream to the cells of the body. Taken into cells, insulin is necessary for the metabolism of glucose for energy.

Insulin dependent diabetes mellitus (IDDM). Diabetes mellitus is that which requires treatment by insulin injection for proper control.

Intracranial. Inside the head.

Ketoacidosis. Abnormal acidity of the blood resulting from poorly controlled Type I diabetes mellitus.

Ketosis. See *ketoacidosis*.

Metabolism. The total chemical and physical activity of the body associated with the production and maintenance of life.

Myopathy. Any disorder affecting muscle tissue; myopathy results in muscle weakness.

Neovascularization. New blood vessel growth. The word is most frequently used to refer to new blood vessel growth in the retina of the eye as a result of uncontrolled diabetes mellitus. See *proliferative retinopathy*.

Nephrogenic diabetes insipidus. See *diabetes insipidus*.

Neurohypophyseal insufficiency. An abnormal condition associated with excessive loss of body water through the kidneys as a result decreased antidiuretic hormone (ADH). ADH is normally secreted by the neurohypophysis. Also known as *diabetes insipidus*.

Neurohypophysis. The back part of the pituitary gland.

Neuropathy. Any disease of nerves, usually taken to mean peripheral nerves. Peripheral nerves are those connecting the spinal cord to the various organs and tissues of the body. Neuropathy is best demonstrated by weakness, decreased reflexes, loss of sensation and decreased nerve conduction velocity (NCV). Motor neuropathy means affecting the motor nerves that carry impulses away from the spinal cord to stimulate muscles. Sensory neuropathy means affecting the sensory nerves that carry touch, pain, vibration, limb position, heat and cold sensations from the tissues of the body to the spinal cord for transmission to the brain. Not every type of sensation need be affected by the neuropathy.

Non-insulin dependent diabetes mellitus (NIDDM). Diabetes mellitus that does not require control by treatment with insulin injections. NIDDM is most likely to apply to adult-onset (Type II) diabetes mellitus.

Obesity. The excessive accumulation of body fat significantly beyond what is necessary for health. Some authorities attempt to define overweight, obesity, morbid obesity, etc., in terms of specific weights related to a person's sex and height. However, such naming systems are completely arbitrary and not universally accepted.

Osteoporosis. Loss of bone mass—that is, a thinning of bone substance.

Pancreatitis. Inflammation of the pancreas.

Parathyroid glands. Small glands located inside of the thyroid gland that produce parathyroid hormone.

Parathyroid hormone (PTH). A hormone important in the way the body regulates the use of calcium. PTH tends to raise blood calcium levels and has the opposite effect as calcitonin. Also known as *parathormone*. Normal PTH values are about 10–50 or 60 picograms/milliliter (pg/ml), increasing with age.

Peripheral arterial disease. Any disease of the arteries in the arms or legs.

Peripheral neuropathy. See *neuropathy*.

Pitressin. Trade name for a synthesized drug that is exactly like human antidiuretic hormone.

Pituitary gland. Pea-sized gland that hangs down from the bottom of the brain on a stalk. It produces a wide range of

Definitions (continued)

important hormones, including sex hormones, adrenocorticotrophic hormone that stimulates the adrenal glands to release cortisol, growth hormone, thyroid stimulating hormone, anti-diuretic hormone that causes the kidneys to conserve water and oxytocin, which is important in uterine muscle contraction during delivery and expression of milk from the breast during suckling.

Precocious puberty. See *adrenogenital syndrome* and *virilization*.

Proliferative retinopathy. Retinal disease resulting from poorly controlled diabetes mellitus, with excessive new blood vessel growth (neovascularization) and an increased risk of retinal detachment and bleeding into the eye.

Pseudohemaphroditism. See *adrenogenital syndrome* and *virilization*.

Pseudohypoparathyroidism (PHP). Genetic disorder in which the cells for receiving parathyroid hormone contain defective receptors.

Purple striae. Purple abdominal skin markings that may be associated with Cushing's syndrome.

Random blood glucose (RBG). Blood glucose measured without consideration of what the person ate before the test or when it was eaten. In a nonpregnant adult or child, the RBG should not be greater than 200 mg/dl. Also known as random blood sugar (RBS).

Standard deviation. A statistical calculation expressing the amount of deviation of a value from average.

Tetany. Tetany refers to muscular twitching, cramping and spasms caused by hypocalcemia. There may be sudden violent contractions of muscles in the larynx (laryngospasm) with difficulty breathing and spasm of muscles in the hands and feet (carpopedal spasm).

T3 resin uptake. A test of thyroid function; should not be confused with a thyroid scan/uptake.

Thyroid gland. Gland in the front part of the neck that produces thyroid hormones under the stimulation of thyroid stimulating hormone (TSH) released from the pituitary.

Thyroid hormones. The major thyroid hormones are *thyroxine (T4)* and *triiodothyronine (T3)*. Synthetic forms of these hormones are available to treat hypothyroidism and can be taken as small tablets once a day. Thyroid hormones stimulate the DNA in the nuclei of cells to increase protein synthesis and oxygen consumption and are therefore vital to the body's metabolic activities.

Thyroid scan/uptake. A test of thyroid function by administering radioactive iodine and scanning the thyroid gland. The amount of radioactivity emitted by the thyroid indicates how well it takes up iodine.

Thyroid stimulating hormone (TSH). Hormone released by the pituitary gland to stimulate the thyroid gland to release thyroid hormones. Thyroid hormones in turn feed back onto the pituitary gland and decrease TSH release. High TSH levels indicate hypothyroidism.

Thyroid ultrasound. A method of making images of the thyroid gland using high-frequency sound. It is a harmless and painless test.

Thyroidectomy. Partial or total surgical removal of the thyroid gland.

Trachea. Windpipe.

Turner's syndrome. An inherited disorder of females involving abnormal combination of sex chromosomes.

Vasopressin. See *antidiuretic hormone*.

Virilization. Abnormality associated with the adrenogenital syndrome and refers to the development of male sexual characteristics—such as hirsutism, development of a deep voice, male hair patterns on the scalp and acne, as well as accelerated bone, muscle and genital development. Accelerated male sexual characteristics in boys results in precocious puberty. In girls, the development of male sexual characteristics can result in genital abnormalities, such as enlargement of the clitoris to appear more like a small penis. The development of male sexual characteristics along with female characteristics is known as pseudohemaphroditism. Virilization is also known as masculinization.

A. General Information

Endocrine disorders affect the structure or functions of the body due to too much or too little hormone production. If the hormone disorder affects the function of other organ systems, evaluation should be done under the appropriate listing. For example, increased thyroid hormone could result in an abnormally fast heart rate and heart failure. That part of the impairment would be evaluated under the listings dealing with heart disease (Chapter 19). Lack of insulin could cause retinal disease with loss of vision. That disorder would be evaluated under the listings for visual impairments (Chapter 17). Many hormonal disorders respond to medical treatment, particularly if the only action necessary is replacement of the deficient hormone.

To qualify under the listings, hormonal abnormalities of the required severity must have persisted or be expected to persist, despite therapy, for at least 12 months. The SSA will require a description of the hormone disorder, physical findings and diagnostic laboratory tests. Because of the way labs test for hormone levels, they generally have a wider range of normal for hormones than for other substances. To make up for this variation, the SSA considers the results abnormal if they are outside the normal range or greater than two standard deviations from the average of the testing laboratory. Because of this, the lab report should include information provided by the testing laboratory as to its normal values for the test.

When a listing requires an abnormal test result, such as an elevated hormone level, a number of tests over three months is necessary to establish an impairment likely to last 12 months.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 9.02: Thyroid Disorders (Adults)

The thyroid gland is located in the lower front of the neck, on both sides of the trachea. The major thyroid hormones

are thyroxine (T4) and triiodothyronine (T3). Thyroid hormones stimulate the DNA in the nuclei of cells to increase protein synthesis and oxygen consumption and are therefore vital to the body's metabolic activities. Thyroid hormones are released from the thyroid gland into the bloodstream under the influence thyroid-stimulating hormone (TSH) from the pituitary gland.

There are many types of specific thyroid disorders, but this listing concerns hyperthyroidism and hypothyroidism. The most common form of hyperthyroidism is Graves' disease, also known as diffuse toxic goiter, and this disorder is frequently seen by the SSA. Hyperthyroidism can almost always be controlled with drugs, radioactive iodine to suppress the function of the gland or with surgery. Hypothyroidism is also a common disorder, but is almost always easily treatable with a tiny once-a-day tablet of synthetic human thyroid hormone; such hormone replacement is very safe if the proper dose is given.

In hyperthyroidism, TSH tends to be low and thyroid hormones elevated. In hypothyroidism, TSH tends to be elevated and thyroid hormones low. However, it is possible to have abnormal thyroid tests and actually have normal thyroid function, if a patient is physiologically stressed such as by surgery or trauma.

Possible abnormalities occurring with hyperthyroidism include nervousness, tremors, goiter, abnormal heart rhythms such as a fast heart rate, heart failure, increased sweating, weight loss, increased reflexes, weakness, fatigue, diarrhea and exophthalmos. Exophthalmos can result in blurry or double vision.

Possible abnormalities occurring with hypothyroidism include slowed thinking, decreased reflexes, slowed heart rate, weight gain, cold intolerance, heart failure, weakness, fatigue, physical sluggishness, hair loss, enlarged tongue, coarse thick skin, puffy facial features and enlarged thyroid gland. In extreme cases, coma may result.

In adults, total T4 is about 4–11 micrograms per deciliter (4–11 mcg/dl), but the normal values reported by the testing laboratory are the ones the SSA would use to confirm the diagnosis or determine the adequacy of control by treatment.

a. Listing Level Severity

Impairments resulting from thyroid disorders should be evaluated under whatever listings are appropriate for the body system affected.

b. Residual Functional Capacity

Medical judgment must be applied on a case-by-case basis to determine RFC, taking into account the effect of the

thyroid abnormality on other body organs and your response to treatment. Also see the description of possible complications under the comments about the listing above and discussion of RFC under whatever other listing is being considered. It should be pointed out that the majority of cases of thyroid disorder can be treated so well that RFC restrictions are not required.

2. Listing 109.02: Thyroid Disorders (Children)

The comments under Listing 9.02 apply here, especially regarding clinical manifestations of thyroid disorders.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have the thyroid disorder that satisfies Ⓐ or Ⓑ, below.

- Ⓐ Hyperthyroidism with clinical manifestations despite prescribed treatment. Once such a clinical manifestation of uncontrolled hyperthyroidism is established—such as through abnormal heart rhythms or weight loss—laboratory tests must verify increased thyroid hormone levels.

Additionally, 1, 2 or 3 must be present. The normal reference values of the particular testing laboratory should be used regarding the tests mentioned by the listing. This is particularly important in children because the normal values of thyroid hormone levels vary with age.

1. Elevated total serum thyroxine (T4) and either elevated free (T4) or resin (T3) uptake.
2. Elevated thyroid uptake of radioactive iodine.
3. Elevated serum triiodothyronine (T3).

- Ⓑ Hypothyroidism, with 1, 2 or 3 despite prescribed treatment.

1. IQ of 70 or less. Infants with hypothyroidism who are not treated may have permanent brain damage with resulting mental retardation, a condition known as cretinism. However, hospitals routinely test the thyroid function in infants, and cretinism is rare in the U.S.

Note: Some IQ tests have more than one IQ score. In these cases, the SSA is obligated by its own rules to use the lowest score in deciding if part Ⓑ1 is satisfied.

2. Growth impairment as described under the criteria in Listing 100.02 Ⓐ and Ⓑ. Part Ⓑ2 recognizes that growth impairment can result from hypothyroidism and refers evaluation to the growth impairment listings (Chapter 16).
3. Precocious puberty. Part Ⓑ3 is satisfied by the presence of abnormally early sexual development. Such precocious puberty can occur in boys or girls and is

usually associated with severe hypothyroidism over a prolonged period of time.

3. Listing 9.03: Hyperparathyroidism (Adults)

There are two little parathyroid glands each buried in the right and left part of the thyroid gland. Although they are within the thyroid gland, the parathyroid glands are separate glands that produce parathyroid hormone (PTH). PTH is important in regulating the way the body uses calcium. About 90% of cases of hyperparathyroidism are caused by a benign tumor in a parathyroid gland.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have hyperparathyroidism that satisfies Ⓐ or Ⓑ, below.

- Ⓐ Generalized decalcification of bone found with an x-ray and an elevation of blood calcium levels to 11 mg per deciliter (11 mg/dl) or greater. Part Ⓐ deals with the fact that severe and uncontrolled hyperparathyroidism can have serious consequences regarding dangerous hypercalcemia. Parathyroid hormone causes the absorption of calcium from bones into the bloodstream and therefore tends to raise blood calcium levels. Excessive resorption of calcium from bones (decalcification of bone) can lead to osteoporosis. Even coma and death can result when levels are persistent and extremely high.
- Ⓑ Any resulting impairment should be evaluated under whatever listings are appropriate. Part Ⓑ is a reminder that any disorders resulting from hyperparathyroidism should be evaluated under the appropriate listing. Although hypercalcemia may not produce any symptoms when mild, very high calcium levels can cause mental disturbances, abnormal heart rhythms, nausea, vomiting, pancreatitis, weakness, loss of appetite and kidney stones with associated renal failure. For example, kidney stones would be evaluated under the listings dealing with renal failure (Chapter 21). Similarly, heart problems would be evaluated under the cardiovascular listings (Chapter 19).

b. Residual Functional Capacity

Medical judgment must be applied on a case-by-case basis to determine RFC, taking into account the effect of the parathyroid abnormality on other body organs and response to treatment. Also, see the description of possible complications under the comments about the listing above and the discussion of RFC under whatever other listing is being considered. Note that the majority of cases of parathyroid

disorder can be treated so well that RFC restrictions are not required.

4. Listing 109.03: Hyperparathyroidism (Children)

See the comments under adult Listing 9.03. Note that this child listing is much more lenient than the adult listing, since only abnormal laboratory tests are required. However, it is still rare for a child to have uncontrollable hyperparathyroidism. Allowances under this listing are very rare.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have hyperparathyroidism that satisfies Ⓐ or Ⓑ, below.

- Ⓐ Repeatedly elevated serum calcium levels.
- Ⓑ Elevated serum parathyroid hormone levels (PTH).

5. Listing 9.04: Hypoparathyroidism (Adults)

Hypoparathyroidism means abnormally low parathyroid hormone (PTH) output from the parathyroid glands, which are inside the thyroid gland. A frequent cause of this disorder is damage to the parathyroid glands during thyroidectomy, a complication that might not become apparent for years after surgery. When PTH levels are too low, blood calcium levels fall. The risks of hypoparathyroidism are those associated with this hypocalcemia.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have hypoparathyroidism that satisfies Ⓐ, Ⓑ or Ⓒ, below.

- Ⓐ Severe, recurrent, tetany. Part Ⓐ deals with a serious consequence of hypocalcemia: the uncontrollable muscle spasms known as tetany. When tetany develops, calcium levels are dangerously low and affect muscle function. It is not expected or reasonable that tetany be present as a daily occurrence, since such a life-threatening condition would receive medical treatment. Rather, recurrent episodes of tetany would be sufficient to qualify under Part Ⓐ. In the context of this listing, "severe" means "marked" or more than moderate. The SSA does not define how often "recurrent" has to be, leaving it to medical judgment by the person making the disability determination. However, it would be reasonable to accept fewer episodes of recurrent tetany if they are more prolonged and difficult to control.
- Ⓑ Recurrent generalized convulsions. Part Ⓑ is similar to part A, except that it requires recurrent convulsions

affecting the whole body. By their very nature, such convulsions would be "severe"—indeed, life-threatening.

- Ⓒ Cataracts, evaluated under the criteria in listings for visual impairments; see Chapter 17. Such cataracts are a sign of long-standing hypoparathyroidism.

b. Residual Functional Capacity

Medical judgment must be applied on a case-by-case basis to determine RFC, taking into account the effect of the parathyroid disorder on other body organs and response to treatment. For example, if cataracts are a problem, see the discussion of RFCs under the visual impairment listings.

6. Listing 109.04: Hypoparathyroidism and Pseudohypoparathyroidism (Children)

See the comments under adult Listing 9.04. In pseudohypoparathyroidism (PHP) the problem isn't a deficiency in parathyroid hormone, but that the body's cell receptors for the hormone are defective. The result is the same: the parathyroid hormone can't do its job.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have hypoparathyroidism or pseudohypoparathyroidism that satisfies Ⓐ or Ⓑ, below.

- Ⓐ Severe, recurrent, tetany or recurrent convulsions. See comments under Listing 9.04.
- Ⓑ Growth retardation as described under the criteria in Listing 100.02 Ⓐ and Ⓑ (Chapter 16).

7. Listing 9.05: Neurohypophyseal Insufficiency (Diabetes Insipidus) (Adults)

One of the hormones secreted by the neurohypophysis of the pituitary gland is antidiuretic hormone (ADH).

ADH is a hormone that acts on the kidneys to prevent excessive water loss from the body. A deficiency can usually be treated with a replacement form of the hormone delivered as a nasal spray. When the word "diabetes" is used, reference is usually being made to diabetes mellitus (sugar diabetes), which is a common disorder. However, diabetes insipidus (DI) and diabetes mellitus are completely different diseases. One possible cause of DI is intracranial tumors that damage the pituitary gland by pressure.

With diabetes insipidus, the lack of ADH causes abnormally large volumes of water to be urinated away and as a result the concentration of sodium left behind in the blood increases—a condition known as hyponatremia. Also, the increased volume of urine causes the concentration of

dissolved wastes in urine to decrease and such abnormally dilute urine can be detected with a simple test known as the specific gravity (Sp. Gr.). Urine specific gravity is normally in the range of about 1.016–1.022, but falls as the urine becomes diluted. If the Sp. Gr. decreases to 1.005, there is very severe and uncontrolled diabetes insipidus. To see how low your specific gravity is, all you have to do is look at the report of your routine laboratory analysis of the urine (urinalysis).

As excessive water is lost from the body in urine, a person with DI must drink large volumes to replace it. However, dehydration is still likely to occur. This is especially true if the person has an ineffective thirst center in the hypothalamus of the brain, a condition most likely in children and the elderly.

Note: If the pituitary gland is being damaged by pressure from a tumor, there may also be pressure on the nearby optic nerves that carry visual information from the eyes. Therefore, all claimants with pituitary tumors should be considered to have possible visual losses, especially loss of peripheral vision (visual fields). Special tests are needed to measure visual field losses and those are described under the listings for visual impairments (Chapter 17).

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have neurohypophyseal insufficiency causing your urine specific gravity to be 1.005 or below, persistent for at least three months, and recurrent dehydration.

The SSA does not define how often “recurrent” must be. Medical judgment has to be applied on an individual basis, depending on how much the disorder affects ability to function. The more severe the dehydration and associated symptoms, the fewer it would take to be disabling.

b. Residual Functional Capacity

Medical judgment must be applied on a case-by-case basis to determine RFC, taking into account the effect of the diabetes insipidus on other body organs and response to treatment. For example, DI could worsen cardiovascular (Chapter 19) or other disorders. On the other hand, DI could be so well controlled with hormone replacement that no RFC restrictions are needed. If dehydration is sometimes a problem, there should be restriction from heavy work or hot environments that would increase water loss through sweating. If the ADH is difficult to control, but not quite at listing-level severity, then weakness and dehydration could justify an RFC for no more than sedentary work.

8. Listing 109.05: Neurohypophyseal Insufficiency (Diabetes Insipidus) (Children)

See the comments under adult Listing 9.05. Documentation of a child's neurohypophyseal insufficiency requires that one of two possible tests be abnormal. These tests determine the body's ability to release antidiuretic hormone (ADH) from the neurohypophysis of the pituitary gland, which can then be measured in the blood. The tests must be done in a hospital and cannot be ordered by the SSA. However, if they have been done they should be in the child's hospital records with a full interpretation by the treating doctor. (The required tests are actually quite a bit more complex than discussed below and can involve various additional tests on urine and blood as well as administration of ADH to observe its results. But those details are beyond the scope of this book.)

- Water deprivation test. This test is simply based on the fact that when a person is deprived of water, the pituitary normally releases ADH to make the kidneys retain water and pass less of it out as urine.
- Hypertonic saline test. An intravenous infusion of hypertonic saline (concentrated sodium chloride salt solution) is a powerful stimulus to the pituitary gland to release ADH. Therefore, a normal pituitary gland should release ADH to make the kidneys retain water and pass less of it out as urine.

a. Listing Level Severity

For the child's condition to be severe enough to meet. This listing, the child must have neurohypophyseal insufficiency, documented by an abnormal hypertonic saline or water deprivation test. Additionally, the child's condition must satisfy **A**, **B**, **C**, **D** or **E**, below.

- A** Intracranial space-occupying lesion, before or after surgery. Part **A** is satisfied if there is a tumor (“space-occupying lesion”) inside the head that is responsible for damaging the neurohypophysis by pressure against it. Such a tumor could arise from the pituitary gland itself or from outside the pituitary. Part **A** can still be satisfied, even if surgery for the tumor has been performed.
- B** Unresponsiveness to Pitressin. Part **B** is fulfilled if the diabetes insipidus is not corrected by Pitressin, an injectable form of synthetic ADH exactly the same as ADH produced by the body. Other forms of ADH delivered by intranasal spray cannot satisfy part **B**. The purpose of part **B** is to identify the presence of nephrogenic diabetes insipidus. In these instances, kidney disease is the problem rather than lack of ADH, and there will be no improvement with the injected ADH.

- Ⓒ Growth retardation as described under the criteria in listing 100.02Ⓐ and Ⓑ. Part Ⓒ recognizes that growth impairment can result from diabetes insipidus and refers evaluation to the growth impairment listings (Chapter 16).
- Ⓓ Unresponsive hypothalamic thirst center, with chronic or recurrent hyponatremia. Part Ⓓ involves some type of abnormality in the thirst center of the hypothalamus of the brain. When concentrated salt solution in the form of the hypertonic saline test mentioned above is given, a normal thirst center will signal the pituitary gland to release ADH in order to conserve body water. If the child has a defective thirst center, there will be a weak awareness of the need to drink water and episodes of dehydration may occur. With dehydration, the sodium concentration in the blood will increase and this hyponatremia must be documented to satisfy part Ⓓ. The SSA does not define how often “recurrent” must be. Medical judgment has to be applied to claimants on an individual basis, depending on how much the disorder affects the child’s ability to function. The more severe the dehydration and associated symptoms, the fewer episodes of hyponatremia it would take to be disabling.
- Ⓔ Decreased peripheral vision (decreased visual fields) caused by a pituitary abnormality. Part Ⓔ concerns the fact that abnormalities such as pituitary tumors can put pressure on the optic nerves and thereby decrease peripheral vision. A more detailed discussion of peripheral vision can be found in the discussion of listings dealing with visual impairments (Chapter 17).

9. Listing 9.06: Hyperfunction of the Adrenal Cortex (Adults)

Hyperfunction of the adrenal cortex refers to the increased output of hormones from the outer layers of the adrenal glands. This adrenal gland overactivity can occur either because of an abnormality within an adrenal gland itself (primary disorder) or because of excessive stimulation of the adrenal glands by hormones released from the pituitary gland (secondary disorder). For example, the adrenal cortex normally produces just enough cortisol hormone for the body’s needs, under the stimulation of a pituitary hormone known as ACTH. But an adrenal gland tumor can release excessive cortisol on its own, without needing ACTH stimulation—a primary disorder. More often, the adrenal glands have no tumor, but are over-stimulated to produce too much cortisol by excessive ACTH released from a pituitary tumor—a secondary disorder. The listing can be satisfied either way—if there is a primary adrenal disorder of the glands themselves or a secondary disorder causing normal adrenal glands to hyperfunction.

Excessive secretion of cortisol can produce a large number of problems which grouped together are referred to as Cushing’s syndrome. People with Cushing’s syndrome tend to have a rounded facial appearance (called “moon facies” by doctors), purple striae, high blood pressure, obesity concentrated on the trunk of the body, thick skin, prominent fat pads on the upper back, easy bruisability, poor healing of wounds, osteoporosis, poor growth in children, irregular menstruation, diabetes mellitus, kidney stones, myopathy and in some cases mental impairment.

While abnormally increased cortisol production is the most frequent type of adrenal hyperfunction, there are other hormones produced in the adrenal cortex that can be secreted in excessive amounts. For instance, there are disorders classified as hyperaldosteronism, in which the adrenal cortex releases too much of the hormone aldosterone. The result can be high blood pressure. There are also disorders of the adrenal cortex involving release of excessive amounts of hormones with activities affecting sexual development, resulting in the adrenogenital syndrome. The adrenogenital syndrome is of particular interest in children (see Listing 109.11), because it can result in abnormal early sexual development in boys (precocious puberty) and development of male sex characteristics in girls (virilization or masculinization).

Because of the large number of possible effects of various excessive adrenal cortex hormones on different organs of the body, this listing has no specific criteria. Rather, it refers evaluation to whatever listing would be most appropriate. For example, high blood pressure would be evaluated under the cardiovascular listings (Chapter 19) while the effects of osteoporosis would be considered under the musculoskeletal listings (Chapter 16) and kidney disease would be evaluated under the listings dealing with renal disease (Chapter 21). If high blood pressure resulted in a stroke, evaluation would be done under the neurological listings (Chapter 26).

a. Listing Level Severity

To determine whether the required level of severity is met, the SSA would evaluate the resulting impairment under the criteria for the affected body system.

b. Residual Functional Capacity

Medical judgment must be applied on a case-by-case basis to determine RFC, taking into account the effect of the disorder on other body organs and response to treatment. See the discussion of RFC under whatever other listings are appropriate to the affected body system. The additional limiting effects of obesity in cases of Cushing’s syndrome

should be remembered, as well as possible decreased muscle strength as a result of excessive cortisol production.

10. Listing 109.06: Hyperfunction of the Adrenal Cortex (Children)

See the comments under adult Listing 9.06. However, this child listing concerns only excessive cortisol hormone secretion from the adrenal glands. Such increased cortisol can result in Cushing's syndrome, just as it can in adults. Adrenal cortex hyperfunction resulting in the adrenogenital syndrome is considered under Listing 109.11.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have hyperfunction of the adrenal cortex (primary or secondary) that satisfies both parts ① and ②, below.

① Elevated 17-hydroxycorticosteroids in the urine (or elevated 17-ketogenic steroids). Part ① deals with the fact that compounds known as 17-hydroxycorticosteroids (17-OHCS) are found in the urine in increased amounts when the adrenal glands secrete excessive cortisol. This happens because 17-OHCS are a metabolic breakdown product of cortisol. Normal values of 17-OHCS depend on the normal reference values used by the testing laboratory. However, as a general guide, normal results are:

less than 8 years of age	urine 17-OHCS: less than 1.5 mg/24 hours
8–12 years of age	urine 17-OHCS: less than 4.5 mg/24 hours
over 12 years of age (boys)	urine 17-OHCS: 4.5–12 mg/24 hours
over 12 years of age (girls)	urine 17-OHCS: 2.5–10 mg/24 hours

If normal values are exceeded, then part ① is satisfied. All you have to do is read the normal values off of the laboratory testing report, which should be in the medical records of the child's treating doctor or in hospital records.

Measurement of 17-ketogenic steroids (17-KS) in the urine is an obsolete test, but mentioned here because it is still in the listing. 17-KS are actually 17-OHCS compounds altered by a laboratory procedure, and have the same meaning as increased 17-OHCS regarding diagnosing increased cortisol output from the adrenal glands.

② Failure of 17-hydroxycorticosteroids (or 17-ketogenic steroids) to fall with administration of a low-dose dexamethasone suppression test. Part ② requires a dexametha-

sone suppression test. When the drug dexamethasone is given, there will normally be a fall in cortisol levels in both the blood and urine, as well as a fall in 17-OHCS in the urine. In people with abnormally increased cortisol production, dexamethasone will not suppress the release of cortisol; levels of cortisol will remain high, along with elevated urinary 17-OHCS. The same is true for 17-KS levels.

Since the dexamethasone suppression test involves the administration of a drug, the SSA will not authorize such testing. Test results should be obtainable from the treating doctor, since testing would be required to reach an accurate diagnosis.

11. Listing 109.07: Adrenal Cortical Insufficiency (Children)

Adrenal cortical insufficiency refers to decreased cortisol hormone output by the outer layers of the adrenal glands. Primary adrenal insufficiency (Addison's disease) is caused by disorders involving abnormal adrenal glands, such as infections, trauma, drugs, adrenalectomy, autoimmune diseases and hereditary diseases. In secondary adrenal insufficiency, the adrenal glands are normal but the pituitary gland doesn't release the ACTH needed to stimulate them to produce cortisol.

Cortisol is a steroid hormone necessary to maintain life. Without enough cortisol, blood pressure falls (circulatory collapse) and death may follow. In many instances, the adrenal insufficiency can be treated with steroid drugs that replace the function of cortisol, usually cortisone or hydrocortisone.

The child's adrenal insufficiency must be diagnosed in two steps.

1. Either of the following:

- persistently low blood cortisol levels, or
- persistently low urine levels of the metabolic breakdown product of cortisol known as 17-hydroxycorticosteroids (17-OHCS). (Federal regulations also accept the measurement of low 17-ketogenic steroids (17-KS) in the urine; however, measurement of 17-KS is generally considered obsolete.)

2. The adrenal glands must be unresponsive to stimulation by injected ACTH. In other words, the child must have abnormal adrenal glands—that is, primary adrenal insufficiency.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have adrenal cortical insufficiency

with recent, recurrent episodes of circulatory collapse. Any episodes of circulatory collapse (adrenal crisis) related to the listing would require hospitalization. The SSA does not define recent or recurrent. In general, most events over three months past would not be considered recent. Certainly, events more than six months old would not be recent by reasonable medical judgment. Recent should be interpreted in light of the fact that disability is based on problems present at the time of disability determination and expected to last a minimum of 12 months. A child with an episode of circulatory collapse many months before application for disability should be considered stable with treatment, rather than having an ongoing problem. Recurrent is a matter of medical judgment, depending on how much the disorder affects the child's ability to function. The more severe the episodes of circulatory collapse and associated symptoms, the fewer it would take to be disabling.

12. Listing 9.08: Diabetes Mellitus (Adults)

Diabetes mellitus is a common and serious disorder and also a frequent impairment seen in disability determination cases. Diabetes mellitus should not be confused with diabetes insipidus, a completely different and much less common disorder. Diabetes mellitus is associated with insufficient insulin, but also can be worsened by the resistance of cells to the effects of the insulin that is present. There are some very basic facts you should know about diabetes mellitus to understand this listing.

Glucose is the basic source of energy for cells, and insulin is required for glucose to enter cells. With insufficient insulin, hyperglycemia results because glucose cannot be utilized.

If the diabetes is mild enough, it can be treated with diet, exercise and oral medications that either increase insulin secretion from the pancreas or increase the effectiveness of the insulin that remains. Diet and exercise help because obesity and lack of exercise increase insulin resistance. When diabetes can be treated without insulin, it is called non-insulin dependent diabetes mellitus (NIDDM).

However, when severe diabetes is present, treatment by insulin injection is required. Diabetes that requires treatment with insulin is called insulin dependent diabetes mellitus (IDDM).

There are two basic types of diabetes mellitus:

Type I. In Type I diabetes, onset is earlier in life and it is also referred to as juvenile diabetes. Most cases of Type I diabetes are now known to be caused by an autoimmune disorder in which the person's own immune system destroys the pancreatic cells that produce insulin. Type I diabetics usually require insulin.

Type II. Type II diabetes is extremely common, because obesity and lack of physical exercise increase the resistance of the body's cells to the utilization of insulin. It is more likely in middle-aged and overweight people who do not exercise regularly. Therefore, it is also known as adult-onset diabetes. Type II diabetes can sometimes be controlled with oral drugs, but progression to insulin dependence is not unusual.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have diabetes mellitus that satisfies ①, ② or ③, below.

- ① Neuropathy which results in persistent difficulty standing and walking, or persistent difficulty using the hands, including both gross and dexterous movements of the fingers. Part ① recognizes the importance of neuropathy in diabetes. Sensory neuropathy causing numbness or confusion about the position of the legs can make standing and walking difficult or interfere with ability to work with the hands. Motor neuropathy can decrease strength in the arms and legs. Either sensory or motor neuropathy can qualify, or a mixture of the two. Two extremities must be involved, but it could involve two legs (most common), two arms or one arm and one leg. If your legs are involved, the listing does not require that you need an assistive device like a cane or crutch to walk—but it should be severe enough that you cannot do even sedentary work requiring standing or walking a total of two hours during an eight-hour workday. "Gross" movements of the hands are the ability to handle larger objects regarding lifting, carrying and grasping. For example, grasping a doorknob or other object about the size of a tennis ball or picking up a chair would be a gross movement. "Dexterous" movements are those that require more coordination and speed, such as manipulating small objects, and good separate control of each individual finger. For instance, playing a musical instrument, sewing, typing, picking up coins and buttoning clothes are all dexterous movements. During physical examinations, you should be able to quickly and easily touch each of your fingertips to your thumb in rapid succession, if your dexterous abilities are intact.
- ② Episodes of acidosis occurring on the average of once every two months. Documentation must be by appropriate blood tests. Part ② takes into account that severe, uncontrolled diabetes may result in ketoacidosis. In ketoacidosis, the body can't metabolize glucose for energy since lack of insulin prevents its entry into cells. Therefore, fats are used for energy, resulting in breakdown

products called ketones. These ketones increase blood acidity. Diabetic ketoacidosis (DKA) is life threatening and must be treated in a hospital. If you've had such episodes they would be documented in your medical records.

- © Retinitis proliferans. Evaluate under the listings for visual impairments. Part © deals with the fact that poorly controlled diabetes is a major cause of blindness. If the severe retinal damage characteristic of retinitis proliferans is present, evaluation is done under those listings dealing with visual disorders (see Chapter 17).

Note: The fact that your disorder might not satisfy any part of this specific diabetic listing does not mean that you couldn't meet another listing. For example, severe diabetes can make heart disease much worse. If you have heart disease, you would also want to consider the cardiovascular listings (Chapter 19). Diabetes is also a major cause of kidney failure, which would be evaluated under the listings dealing with kidney disease (Chapter 21).

b. Residual Functional Capacity

Medical judgment must be applied on a case-by-case basis to determine RFC, taking into account the effect of the diabetes on other body organs and response to treatment. Some diabetics require no functional restrictions, because they either have mild diabetes mellitus or have excellent control with no significant organ damage. Others may have visual impairments, heart failure, difficulty walking because of neuropathy or decreased blood flow in their leg arteries, etc. Make sure that the SSA is aware of your limitations in daily activities and how such restrictions relate to your diabetes. You can record your difficulties and symptoms on the forms the SSA will give you, but it is even better if your treating doctor discusses your problems in your medical records. For example, the comments about neuropathy under part Ⓐ of the listing also apply to RFC considerations when of a lesser degree of severity. If you have diabetes-related or other conditions not considered by this listing, also refer to the RFC discussions under whatever listing is appropriate.

13. Listing 109.08: Juvenile Diabetes Mellitus (Children)

See the comments about diabetes under adult Listing 9.08, keeping in mind that specific parts of the adult and child listings are not the same.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have insulin dependent juvenile diabetes mellitus that satisfies Ⓐ, Ⓑ, Ⓒ or Ⓓ, below, despite prescribed therapy.

- Ⓐ Recent, recurrent hospitalizations with acidosis. The SSA does not define recent or recurrent. In general, most events over three months past would not be considered recent. Certainly, events more than six months old would not be recent by reasonable medical judgment. Recent should be interpreted in light of the fact that disability is based on problems present at the time of disability determination and expected to last a minimum of 12 months. A child with an episode of acidosis many months before applying for disability should be considered stable with treatment, rather than as having an ongoing problem. Recurrent is a matter of medical judgment, depending on how much the disorder affects the child's ability to function. The more severe the episodes of acidosis, the fewer it would take to be disabling.
- Ⓑ Recent, recurrent episodes of hypoglycemia. Part Ⓑ deals with episodes of low blood glucose. Although diabetes is associated with high blood glucose, a mistake resulting in insulin overdosage can cause hypoglycemia. Such hypoglycemia can be a serious problem in diabetics, resulting in brain damage, coma and even death. Also, some cases of diabetes are difficult to control and are called "brittle" diabetes. These children are more susceptible to developing accidental hypoglycemia. Except for involving hypoglycemia rather than acidosis, the terms "recent" and "recurrent" have the same meaning here as for part Ⓐ.
- Ⓒ Growth retardation as described under the criteria in Listing 100.02Ⓐ or Ⓑ (Chapter 16).
- Ⓓ Impaired kidney function that satisfies the criteria of the listings that deal with kidney disease (Chapter 21).

14. Listing 109.09: Iatrogenic Hypercorticotoid State (Children)

Iatrogenic hypercorticotoid states are those caused by steroid drugs like prednisone when taken for a prolonged period of time, as might be necessary to treat certain immune diseases, cancers, skin diseases, blood diseases, respiratory diseases and eye diseases. The long-term side effects of such treatment can result in Cushing's syndrome. (See the definition of Cushing's syndrome and the discussion under

adult Listing 9.06 for a description of the abnormalities associated with this disorder.)

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have been through iatrogenic glucocorticoid therapy resulting in Ⓐ, Ⓑ, Ⓒ, Ⓓ or Ⓔ, below.

- Ⓐ Osteoporosis. Part Ⓐ refers to osteoporosis, which only needs to be severe enough to be a definite diagnosis—the SSA's own regulation does not have any requirement that the osteoporosis be advanced (marked) in severity. If there is a chance the child has osteoporosis, bone densitometry x-rays should be done rather than plain x-rays. Osteoporosis is visible on plain x-rays only when a large amount of bone has been lost. Therefore, the child could possibly be deprived of a legitimate allowance if the SSA misses osteoporosis by relying on plain x-rays. Bone densitometry testing is widely available and could certainly be purchased by the SSA if necessary.
- Ⓑ Growth retardation as described under the criteria in Listing 100.02Ⓐ or Ⓑ (Chapter 16).
- Ⓒ Diabetes mellitus as described under the criteria in Listing 109.08.
- Ⓓ Myopathy as described under the criteria in Listing 111.06 (Chapter 26).
- Ⓔ Emotional disorder as described under the criteria in the mental disorder listings (Chapter 27). (In some children, steroids can produce anxiety, depression, insomnia, mood swings, personality changes, euphoria and even psychosis; also, steroids might aggravate emotional problems already present.)

15. Listing 109.10: Pituitary Dwarfism (Children)

Pituitary dwarfism results from insufficient growth hormone released from the pituitary gland. Decreased growth hormone can be caused by damage to the pituitary gland or as a result of a tumor. Growth hormone deficiency can also be caused by damage to the hypothalamus of the brain, which releases another hormone—growth hormone releasing hormone—to stimulate the pituitary to release growth hormone. Either cause of dwarfism could potentially qualify under this listing.

With the advent of the genetic engineering of bacteria, human growth hormone is available to treat those children who are deficient. This listing refers evaluation to the growth impairment Listing 100.02Ⓑ (Chapter 16).

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have pituitary dwarfism with documented growth hormone deficiency and growth impairment as described under the criteria in Listing 100.02B.

16. Listing 109.11 Adrenogenital Syndrome (Children)

Adrenogenital syndrome results from a genetic enzyme deficiency in the adrenal glands. That deficiency causes an increased secretion of adrenal hormones that produce male sex characteristics—a process known as virilization (see “Definitions” at the beginning of this chapter). In male children, the effect of virilization is precocious puberty. In female children, the effect is pseudohemaphroditism.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have adrenogenital syndrome that satisfies Ⓐ, Ⓑ or Ⓒ, below.

- Ⓐ Recent, recurrent salt-losing episodes despite prescribed therapy. Part Ⓐ is satisfied by excessive loss of sodium from the body. Events known as “salt-losing episodes” are present in the majority of cases and start soon after birth with weakness, vomiting and dehydration. The SSA does not define how often “recurrent” must be. Medical judgment has to be applied on an individual basis, depending on how much the disorder affects the child's ability to function. The more severe the salt-losing episodes and associated symptoms, the fewer it would take to be disabling. The SSA also does not define recent, but it is difficult to see how most events over three months in the past could be considered recent. Certainly, events more than six months old would not be recent by reasonable medical judgment. The word “recent” should be interpreted in light of the fact that disability is based on problems supposedly present at the time of disability determination and expected to last a minimum of 12 months. A child with a salt-losing episode many months before applying for disability should be considered stable with treatment, rather than as having an ongoing problem.
- Ⓑ Inadequate hormone replacement therapy, as manifested by an accelerated bone age and virilization. Part Ⓑ applies to those children whose treatment is inadequate. The treatment is administration of the steroid hormone hydrocortisone, which must be given indefinitely. Hydrocortisone inhibits release of another hormone, ACTH, from the pituitary gland. Decreased ACTH means that

there is less stimulation of the adrenal glands to produce the abnormal hormones causing the sexual development problems. However, if the problem is a tumor in the adrenal glands, this treatment won't work, and surgery is required to remove the tumor. Virilization can be determined through physical examination. Bone age can be determined from x-rays.

- © Growth impairment as described under the criteria in Listing 100.02 Ⓐ and Ⓑ (Chapter 16).

17. Listing 109.12: Hypoglycemia (Children)

In children, hypoglycemia is present if the fasting blood glucose (FBG) falls below 50 mg/dl and there are symptoms. In infants, hypoglycemia is not considered present by some authorities until the FBG falls under 40 mg/dl. The SSA does not specifically provide a blood sugar number to officially represent hypoglycemia, but it does say that laboratory tests can be considered abnormal if outside of the normal range used by the testing laboratory or if more than two standard deviations from the average normal value used by the testing laboratory. The severe physical abnormalities (convulsions or coma) required by the listing will not occur until blood glucose levels fall to values below the 40–50 mg/dl range as needed to affect the brain.

One cause of hypoglycemia in children is a condition known as ketotic hypoglycemia, which is a disorder of metabolism involving proteins. Frequent feedings with foods high in carbohydrates and protein are used to treat the disorder. Accidental insulin overdose, overdose with oral drugs used to treat diabetes mellitus or overdose with some other drugs may result in hypoglycemia. Other possible causes of hypoglycemia in children include adrenal insufficiency, hereditary enzyme deficiencies and pancreatic tumors that produce excessive insulin (insulinomas).

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have hypoglycemia with recent, recurrent hypoglycemia episodes producing convulsions or coma. The SSA does not define recent or recurrent. In general, most events over three months past would not be considered recent. Certainly, events more than six months old would not be recent by reasonable medical judgment. Recent should be interpreted in light of the fact that disability is based on problems present at the time of disability determination and expected to last a minimum of 12 months. A child with an episode of hypoglycemia many months before application for disability should be considered stable with treatment, rather than as having an ongoing problem.

Recurrent is a matter of medical judgment, depending on how much the disorder affects the child's ability to function. The more severe the episodes of hypoglycemia, the fewer it would take to be disabling.

18. Listing 109.13: Gonadal Dysgenesis (Turner's Syndrome) (Children)

Cells normally have 46 chromosomes—44 somatic (non-sex) chromosomes occurring as 22 pairs and two X or Y sex chromosomes. The sex chromosomes in males are normally an XY combination and in females XX. A normal male's chromosome number would be written as 46, XY and a normal female as 46, XX. Gonadal dysgenesis, more commonly known as Turner's syndrome, is a genetic disorder of females characterized by missing one of the two X chromosomes that are normally present in female cells. Such a condition would be written as 45, X. However, there are also variations of Turner's syndrome known as mosaics, in which cells in the same person's body have different genetic make-ups. A common mosaic in Turner's syndrome is that some cells are normal with two X chromosomes, while other cells are missing an X chromosome. Such conditions would be written 45, X/46, XX. In another type of mosaic abnormality, some cells are missing an X chromosome while others have a Y chromosome substituted for one of the X chromosomes (45, X/46, XY). Other combinations are also possible.

Children or adults with Turner's syndrome can have hormonal abnormalities, impairment of growth, hearing loss and neurological problems involving the failure to integrate sensation and movement on a fine level. Reproductive abnormalities are typically present. However, intelligence is usually normal. Heart abnormalities may be present, as well as abnormalities of the kidneys and bony skeleton. In other words, evaluation of Turner's syndrome requires thorough physical examination and laboratory testing. This information should be available to the SSA. Evaluation of growth would be considered under the growth impairment listings (Chapter 16); hearing loss under the appropriate listings for hearing loss (Chapter 17); heart disorders under the cardiovascular listings (Chapter 19); and neurological problems under the nervous system listings (Chapter 26).

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have gonadal dysgenesis (Turner's syndrome), proven by chromosomal analysis. The SSA would evaluate the resulting impairment under the criteria for the appropriate body system. ■

Chapter 25

Multiple Body System Disorders

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Acquired disorders. Disorders that are not of genetic (hereditary) origin.

Age-appropriate activities. Activities normally expected for a child's age.

Anencephaly. Birth defect characterized by absence of most of the brain.

Anus. Terminal opening of the gastrointestinal tract, through which feces exit the body.

Brushfield spots. White speckles in the iris of the eyes of those with Down syndrome.

Cerebrospinal fluid (CSF). Clear, watery, fluid that bathes the spinal cord and brain and circulates within the brain.

Chromosomes. The structures in the nuclei of cells that carry the genetic (DNA) content of an individual. Cells normally have 46 chromosomes, counting the sex chromosomes—22 pairs of somatic chromosomes and one pair of sex chromosomes. The sex chromosomes in males are one X and one Y chromosome (XY) and in females, two X chromosomes (XX). The gene make-up of a normal female would be written 46, XX, and a normal male would be 46, XY.

Congenital. Dating from the time of birth. Congenital disorders are not necessarily hereditary, because some congenital disorders arise from events that happen while in the uterus rather than as a result of abnormal genes.

Cyclopia. Birth defect characterized by having only one centrally placed eye and other abnormalities.

Deoxyribonucleic acid (DNA). The chemical structure in chromosomes of which genes are composed.

Down syndrome. Hereditary disorder involving the presence of an extra #21 chromosome in cells, associated with mental retardation and possible abnormalities in various organs such as the heart. Also known as Trisomy 21.

Epicanthic folds. Folds of tissue over the inner corners of the eyes.

Extrauterine life. Life after birth.

Fetal alcohol syndrome. Abnormalities in a child resulting from the mother using alcohol during pregnancy.

Facies. The appearance of the face. In some physical disorders, such as Down syndrome and fetal alcohol syndrome, there is a characteristic facies related to the physical appearance of the face. When discussing mental disorders, facies may be used to describe emotional expression, such as "The depressed child had a sad facies."

Fragile X syndrome. A common hereditary disorder associated with breakage in the X chromosome and characterized by mental retardation as well as other possible abnormalities.

Genes. Pieces of DNA that make up control units for the growth and function of an organism.

Hereditary disorders. Disorders resulting from genetic abnormalities.

Herpes encephalitis. Infection of the brain with herpes virus.

Hydrocephalus. Accumulation of excessive cerebrospinal fluid in the ventricles of the brain. Hydrocephalus may be associated with increased pressure in the ventricles or with normal pressures. The latter is known as normal pressure hydrocephalus (NPH).

Hypothyroidism. Disorder in which there is a deficiency in thyroid hormone. Also known as *myxedema*.

Hypotonia. Poor muscle tone. A muscle with no tone is called flaccid.

Imperforate anus. Absence of an anus.

Intestinal atresia. Failure of the intestine to develop.

Macrocephaly. An abnormally large head, such as may be seen with hydrocephalus.

Microcephaly. Abnormally small head, such as may be seen with some genetic disorders associated with severe mental retardation.

Mosaic. Any genetic disorder in which different cells in the body have different genetic make-ups. For example, if some cells have an extra chromosome #21 and some cells have a normal number of chromosomes, then the person is said to be a mosaic for Down's syndrome.

Motor dysfunction. Any abnormality related to movement, such as weakness, paralysis, tremors or lack of coordination.

Motor function. Abilities related to movement, such as walking and use of the hands and arms.

Multiple body system disorders. Disorders that affect more than one type of organ, such as the heart and brain.

Phenylketonuria (PKU). Hereditary enzyme deficiency associated with mental retardation.

Postural reaction deficit. Decreased ability to recover balance when disturbed.

Primitive reflexes. Reflexes seen in newborn infants, such as rooting and sucking reflexes.

Protozoan. Microscopic animal.

Syndrome. A set of signs and symptoms that occur together.

Tay-Sachs disease. Hereditary enzyme deficiency resulting in severe mental retardation.

Ventricles (of brain). Any one of the connected cavities in the brain that contain cerebrospinal fluid.

A. General Information

Down syndrome and other genetic disorders must be diagnosed with chromosomal analysis as well as physical examination. However, the SSA does not require actual laboratory reports if the available medical records convincingly state that the appropriate test confirming the diagnosis was done at some time in the past. For example, a treating doctor might refer in medical records to chromosomal analysis confirming Down syndrome in a child at some time in the past. If the records clearly show the physical abnormalities of Down syndrome, the SSA would not require the claimant to undergo repeat chromosomal testing.

Regarding children, disorders that qualify under these listings are those associated with life-threatening catastrophic congenital abnormalities and other serious hereditary, congenital or acquired disorders that affect two or more body systems and are expected to:

1. Result in early death or attainment of a developmental level less than that expected of a two-year-old child, such as anencephaly or Tay-Sachs disease (Listing 110.08).
2. Produce significant and long-term—if not lifelong—interference with the child's ability to carry on age-appropriate activities, defined as activities that most other children of the same age can do. The SSA considers such significant interference to exist when a child is not capable of abilities possessed by a normal child two-thirds or less of their age and when the lag in development has lasted, or could be expected to last, at least 12 months. For example, suppose a nine-year-old child claimant is given a test of developmental abilities and gets a score indicating overall abilities (motor abilities, eating, language, etc.) of a six-year-old child. The child's developmental age would be six years, or two-thirds that of a normal nine-year-old. (Listings 110.06, 110.07A.)

Regarding adults, Listing 10.06 is the same as child Listing 110.06.

Chromosomal abnormalities other than full-blown Down syndrome—for example, mosaic Down syndrome, fragile X syndrome, phenylketonuria and fetal alcohol syndrome, produce a pattern of multiple impairments with a wide range of severity. Therefore, the effects of these impairments should be evaluated under whatever listings deal with the actual disorder. For instance, heart disease would be evaluated under the appropriate heart disease listing—such as the listing for heart failure, if that is the problem (Chapter 19).

Because of the possible involvement of multiple body systems—such as the heart and brain—the SSA should

always consider the combined effect of multiple impairments. The SSA must decide whether they are equal in severity to a combination of listings, even if the child or adult has no single impairment that would satisfy a listing. As in the evaluation of any impairment, these determinations should be made by a doctor—not an examiner, claim manager or other layperson.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 10.06: Down Syndrome (Excluding Mosaic Down Syndrome) (Adults)

Down syndrome (trisomy 21) is a genetic disorder involving the presence of three copies of chromosome #21 in cells, instead of the normal two copies. The presence of this extra chromosome always leads to mental retardation. There is a characteristic facies: flattened bridge of the nose, malformed ears, a large protruding tongue, flattening of the back of the skull, Brushfield spots, epicanthic folds and a slanting of the eyes. Other features of Down syndrome are malformed hands with short fingers and a wide palm with a prominent crease (“simian crease”). Down syndrome is the most common chromosomal abnormality producing a syndrome in humans. The chances of having a Down syndrome baby steadily increase with the age of the mother. In addition to the above characteristic abnormalities, Down syndrome may be associated with congenital heart disease and intestinal malformations, such as imperforate anus and intestinal atresia.

Only a valid diagnosis of nonmosaic Down syndrome is required. Then the required severity as described above is automatically considered to exist. (See “General Information,” Section 2.)

This listing applies only to claimants who have full-blown (nonmosaic) Down syndrome, in which all of the body's cells carry the abnormal extra #21 chromosome. About 95–99% of Down syndrome cases are nonmosaic and so would qualify.

Cases of mosaic Down syndrome, in which some of the body's cells are normal and others abnormal, are not evaluated under this listing. Mosaics vary in the severity of their disorder; some may have normal intelligence and very little evidence of any significant physical abnormality. Those unusual claimants with mosaic Down syndrome would be evaluated under whatever listings deal with the physical or mental disorders they have associated with their Down syndrome, such as described above. For instance, heart disease would be evaluated under the cardiovascular disease listings (Chapter 19) and sub-average intelligence would be evaluated under the mental disorders listings (Chapter 27).

a. Listing Level Severity

For the applicant's condition to be severe enough to meet the listing, the applicant must have nonmosaic Down syndrome, established by physical examination and chromosomal analysis. The SSA will consider the individual disabled from birth.

b. Residual Functional Capacity

An analysis of RFC is not necessary under this listing, since diagnosis of nonmosaic Down syndrome is an automatic allowance. RFC for mosaic Down syndrome would depend on the types of problems present, if any, and reference should be made to the RFC discussion under the appropriate listings for the types of disorders involved.

2. Listing 110.06: Down Syndrome (Excluding Mosaic Down Syndrome) (Children)

See comments under adult Listing 10.06. As in adults, full-blown Down syndrome is an automatic allowance.

Child claimants with mosaic Down syndrome must be evaluated under the criteria of Listing 110.07. However, the majority of children with Down syndrome have the non-mosaic form of the disorder and therefore would qualify under this listing.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have nonmosaic Down syndrome, established by physical examination and chromosomal analysis. The SSA will consider the child disabled from birth.

3. Listing 110.07: Multiple Body Dysfunction (Children)

This listing is for evaluation of any hereditary, congenital or acquired disorder in which multiple medical abnormalities are likely to occur. One disorder specifically mentioned by the SSA is phenylketonuria (PKU), which is caused by deficiency of an enzyme necessary to breakdown excess amounts of the essential amino acid known as phenylalanine. Treatment of PKU involves dietary control of phenylalanine intake; untreated disease will result in microcephaly, severe mental retardation and growth retardation.

Mosaic Down syndrome is one disorder that could potentially qualify under this listing. See the comments under adult Listing 10.06 regarding mosaic Down syndrome.

Another disorder that could be considered under this listing is fetal alcohol syndrome. In this condition, a child can have growth retardation, poor weight gain, facial abnormalities, heart defects, joint abnormalities and varying degrees of mental deficiency.

Other conditions specifically mentioned by the SSA in relation to this listing are infections such as toxoplasmosis, rubella syndrome, cytomegalic inclusion disease and herpes encephalitis. Toxoplasmosis is caused by a protozoan parasite. The others are viral infections and all can result in persistent illness. These are common examples of conditions that can result in multiple body disorders, but any impairment satisfying the requirements of the listing could qualify.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have multiple body dysfunction due to any confirmed hereditary, congenital or acquired condition. Additionally, the child's condition must satisfy Ⓐ, Ⓑ, Ⓒ, Ⓓ, Ⓔ or Ⓕ, below.

- Ⓐ Persistent motor dysfunction resulting from hypotonia and/or musculoskeletal weakness, postural reaction deficit, abnormal primitive reflexes or other nervous system abnormalities. Additionally, there must be significant interference with the child's ability to engage in age-appropriate activities or personal care activities. In an infant or young child, such activities include controlling the position of the head, swallowing, following objects with the eyes, reaching, grasping, turning, sitting, crawling, walking, taking solid food or feeding. Part Ⓐ is satisfied by the child's inability to move about in a way

that is appropriate for her age. (See “General Information,” Section 2, above, for more on the severity required.) This kind of motor dysfunction could result from neurological problems, such as weakness associated with hypotonia. The listing also recognizes that weakness could result from musculoskeletal problems such as various kinds of deformities. For example, there could be a deformity of the spine or pelvic bones that affects the ability to stand or walk; or the joints in the hands may be abnormal so that the ability to grasp or use the fingers is decreased. Each case has to be considered on an individual basis, but the cause is not as important as the degree of functional loss.

- ⓑ Mental impairment as described under the criteria of Listing 112.05 or 112.12. Part ⓑ refers evaluation of mental disorders to the appropriate listings for mental retardation (Listing 112.05, Chapter 27) or developmental and emotional problems in newborn and younger infants (Listing 112.12, Chapter 27).
- ⓒ Growth impairment as described under the criteria in listing 100.02ⓐ or ⓑ (Chapter 16).
- ⓓ Significant interference with communication due to speech, hearing or visual impairments as described under the criteria in Listings 102 and following (Chapter 17) or 111.09 (Chapter 26).
- ⓔ Cardiovascular disorders as described under the criteria of the Listings 104 and following (Chapter 19).
- ⓕ Other impairments such as, but not limited to malnutrition (Listing 105.02, Chapter 20), hypothyroidism (Listing 109.02, Chapter 24) or seizures (Listings 111.02 or 111.03, Chapter 26), should be evaluated under the criteria of those listings or the criteria for the affected body system.

4. Listing 110.08: Catastrophic Congenital Abnormalities (Children)

Catastrophic abnormalities at the time of birth are those so severe that only brief survival is possible or growth and development will predictably stop at such a young age that the child will always remain helpless as a result of severe mental retardation.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have catastrophic congenital abnormalities that satisfy part ⓐ or ⓑ, below.

- ⓐ Part ⓐ concerns those genetic disorders that are not usually compatible with survival after birth. Examples include anencephaly, cyclopia (one eye, brain malformation and a fleshy protuberance on the forehead) and other lethal abnormalities such as trisomy D or E. Trisomy D is an older term for trisomy-13, in which there is an extra chromosome #13 in body cells instead of the normal two. Trisomy E is an older term for trisomy-18, in which there is an extra chromosome #18 in body cells instead of the normal two. In both of these disorders, infants have mental retardation, heart disease, kidney disease and other abnormalities. Trisomy 18 is common, being the second most frequent abnormality of non-sex chromosomes in humans and occurring in about 1 in 8,000 births. In the above examples, death occurs within several months of birth, although there may be very rare exceptions.
- ⓑ A positive diagnosis where the child is not expected to ever attain the growth and developmental level of a two-year-old. Examples given by the SSA include the genetic disorders of Tay-Sachs disease and cri du chat syndrome, but allowance is not limited to those disorders.

In Tay-Sachs disease there is deficiency of an enzyme leading to the accumulation of compounds that damage the brain. Severe degeneration of the brain is evident on imaging studies of that organ. Development may progress normally until about five months of age, but there follows severe mental retardation, blindness and other serious abnormalities such as hypotonia and seizures. There is also a late-onset form of Tay-Sachs that may not be seen until adulthood.

Cri du chat syndrome is caused by a missing piece of chromosome #5. These children are mentally retarded, with microcephaly and malformed heads, skeletal abnormalities and possibly congenital heart disease. ■

Chapter 26

Nervous System Disorders

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Aneurysm (of cerebral artery). Enlarged, weakened areas in a cerebral artery.

Angiography. Any technique to produce images of arteries, such as by x-rays or MRI scans. Usually involves injection of contrast material into the artery to make it visible. Also known as *arteriography*.

Anticonvulsants. Drugs used to treat epilepsy.

Aphasia. Decrease or loss of ability to know or express things, as a result of brain damage.

Arteriovenous malformation (AVM). Abnormal tangle of arteries and veins involving an area of the spinal cord or brain.

Articulation. To speak (utter, enunciate and pronounce). The quality of articulation is reflected by the distinctness or clarity of speech.

Asphyxia. Lack of oxygen.

Astrocytoma. Malignant brain tumors arising from the astrocyte cells of the brain; may be of varying degrees of malignancy.

Ataxia. General term for uncoordinated movement of either the arms or legs. The word is seen most often in reference to an “ataxic gait,” meaning the person has difficulty walking in a normal, smooth manner.

Athetosis. Involuntary, slow, writhing motion of the limbs.

Atrophy. An abnormal decrease in the size of a muscle or organ.

Auditory. Pertaining to hearing.

Auditory brain stem response (ABR). The brain’s electrical activity in response to hearing sounds, which is then computer-analyzed. ABR is not under voluntary control and provides information about the function of the auditory pathways between the ears and the brain. Also known as *brain stem auditory evoked response (BAER)* and *auditory evoked response (AER)*.

Aura. Any subjective sensation or motor abnormality that sometimes comes before an attack of some type of nervous system disorder. For example, an aura may precede the appearance of a migraine headache or an epileptic seizure. Auras can be of many different types—visual, auditory, smells, weakness, nausea and the like.

Autonomic nervous system. That part of the nervous system that carries out its activities without conscious will—such as glandular secretions, heartbeat and movement of the digestive tract.

Benign. Noncancerous.

Biopsy. The process of taking a sample of tissue for detailed analysis of various kinds. Biopsy specimens are observed grossly with the eyes, microscopically with a variety of possible tissue

stains and in some cases may involve specific chemical and DNA analyses.

Bradykinesia. Slowed movements resulting from a neurological disorder.

Brain scan. Any test involving injection of a radioactive isotope (radionuclide) to evaluate brain metabolism or blood flow. Scanners pick up radioactivity and make images of the pattern and degree of uptake in various areas of the brain.

Brain stem. A transitional area between the upper spinal cord and the brain. The brain stem has important functions in sleep and maintenance of consciousness and is the origin of the cranial nerves. It holds numerous important regulatory centers, such as those involving the heart and breathing. The brain stem is delicate and is always manipulated as little as possible during brain operations; pressure or trauma to the brain stem can result in coma or death.

Broad-based gait. Walking with feet wide apart so as to maintain balance.

Bulbar signs. Weakness of the muscles needed for breathing, swallowing, chewing and speaking. Difficulty handling oral secretions (saliva) should be considered a bulbar sign because it means the person cannot swallow adequately. Bulbar signs result from disorders that damage the brain stem motor nerve cells which control these activities. See *brain stem* and *cranial nerves*.

Cardiomyopathy. Any disease of heart muscle.

Carotid arteries. Large arteries in the neck that supply the head and brain with blood. The internal carotid artery (ICA) branches from the common carotid artery to supply the brain, while the external carotid artery (ECA) branches from the common carotid artery to supply the remainder of the head.

Carotid ultrasound. Test producing an image of the carotid arteries in the neck by means of reflected high-frequency sound waves. It is particularly useful in identifying fatty deposits that may decrease blood flow to the brain.

Cerebral angiography. Angiography of the brain; x-ray evaluation of the brain’s blood circulation after injection of a contrast agent.

Cerebral cortex. The thin sheet of cells that makes up the outer surface of the brain and which is responsible for all higher thinking. See *gray matter*.

Cerebral hemispheres. The large bulges of brain tissue above the brain stem, which have fissures (sulci) and ridges (gyri). The cerebral hemispheres are covered with the cerebral cortex.

Cerebrospinal fluid (CSF). Clear, watery fluid that bathes the spinal cord and brain and circulates within the brain.

Cerebrovascular accident (CVA). Stroke. There are basically two kinds of stroke: *hemorrhagic strokes* caused by bleeding in the brain and *thrombotic strokes* caused by blockage of blood flow to a part of the brain.

Definitions (continued)

Chorea. Involuntary jerking motion of the limbs.

Circumduction. Movement of a limb with a circular motion, such as swinging a partially paralyzed leg around to walk. A circumducting gait is common in stroke patients. See *hemiparetic gait*.

Clivus chordoma. Rare, slow-growing tumors arising from fetal remnant cells and occurring at the back and bottom of the skull. They can have varying degrees of malignancy.

Computerized axial tomography (CAT or CT) scan. X-rays taken under computer guidance that can show much greater detail than regular x-rays.

Contrast. Material that is injected during angiography, either for x-rays or MRI scans, to improve image quality.

Convulsion. Violent, involuntary contractions of muscles. Meaning is usually in reference to seizures that involve such involuntary muscle activity. See *seizures*.

Cranial nerves (CN). Nerves arising from the brain stem. The 12 cranial nerves that mainly supply the head are those for hearing, taste, smell, balance, tongue movement, swallowing, facial muscle movement, sight, movement of the eyes, upper back muscles and larynx.

Deep tendon reflexes (DTRs). Brief involuntary muscle contractions caused by stimulation of nerve endings in muscle tendons. For example, tapping on the patella (the tendon below the kneecap) normally causes contraction of the quadriceps (upper thigh muscle) so that the leg extends in a brief kicking motion. This is called a knee-jerk (KJ). Biceps-jerks (BJ) and ankle-jerks (AJ) are other commonly tested deep tendon reflexes.

Dementia. Deterioration of intellectual capacity.

Demyelinating diseases. Disorders, such as multiple sclerosis, that involve damage to the insulating myelin substance that covers some kinds of nerve tracts. Demyelinating diseases may affect the white matter in the brain, as well as peripheral nerves.

Diplopia. Double vision. Diplopia should always cause a doctor to suspect a pituitary tumor pressing on the optic nerves or other tumors affecting the visual areas of the brain.

Discectomy. Removal of part of an intervertebral disc, often done with a laminectomy. Sometimes, a micro-discectomy is possible by making a small surgical incision in the back without performing a laminectomy.

Dysarthria. Inability to speak clearly.

Dysesthesias. Abnormal sensations, especially those involving the sense of touch. Dysesthesias involving a decreased sensitivity to touch are called *hypoesthesias*; those involving increased sensitivity to touch are *hyperesthesias*. Dysesthesias may be present without being touched.

Electroencephalogram (EEG). Recording made of the brain electrical activity, picked up by scalp electrodes and amplified. Unless performed during brain surgery, an EEG does not involve touching the brain.

Electromyogram (EMG). Recording of a muscle's electrical response to electrical stimulation. The size (amplitude), number (frequency) and shape of the electrical outputs from stimulated muscles provides important information that can be related to both nerve diseases and muscle diseases.

Enderterectomy. Surgical procedure to remove blood clots or fatty blockages from an artery. Enderterectomies on the carotid arteries of the neck can help restore blood flow to the brain and prevent strokes.

Ependymal cells. Cells lining the ventricles of the brain.

Ependymblastoma. Cancerous tumor arising from the ependymal cells.

Ependymoma. Benign tumor arising from the ependymal cells.

Epilepsy. Any of a number of possible disorders in which abnormal electrical activity in the brain produces sudden (paroxysmal) changes in consciousness, movements, sensations, mental state or disturbances of the autonomic nervous system or combinations thereof. An episode of epilepsy is known as a seizure.

Festinating gait. A neurological abnormality characterized by an involuntary tendency to take small, increasingly fast steps in order to keep from falling forward.

Flaccid. Absent muscle tone, usually resulting from lack of nervous system stimulation.

Foot-drop. Inability to lift the front part of the foot when walking, so that the toes tend to drag. A foot-drop can be caused by injury to peripheral nerves in the leg, herniated discs or abnormalities that put pressure on certain nerve roots as they leave the spinal cord, injury to the spinal cord or by damage to brain areas necessary to activate the muscles in the leg that are needed to flex the foot upward. See *steppage gait*.

Gait. The manner in which a person walks.

Gray matter. Tissue that contains nervous system cells, such as the cerebral cortex of the brain.

Hemiparetic gait. A gait that occurs with a weak arm and leg, such as caused by a stroke. The weak arm has a short arm swing movement and the weak leg is swung around in a circle (circumducted). See *circumduction*.

Hemiplegia. Paralysis of an arm and leg on the same side of the body.

Herniated nucleus pulposus (HNP). Protrusion of the cartilage-like central part of a intervertebral disc through its fibrous covering. Herniated nucleus pulposus is a frequent cause of radiculitis and back pain and is commonly called a *herniated disc*.

Hydrocephalus. Accumulation of excessive cerebrospinal fluid in the ventricles of the brain. Hydrocephalus may be associated with increased pressure in the ventricles or with normal pressures. The latter is known as *normal pressure hydrocephalus (NPH)*.

Definitions (continued)

Hyperesthesia. Increased skin sensitivity, especially to being touched. For example, a painful burning sensation caused by being touched normally on a certain area of skin would be described as a painful burning hyperesthesia. Hyperesthesia is a type of dysesthesia.

Hyperreflexia. Abnormally fast deep tendon reflex responses, such as would occur in the limb affected by a stroke. Also known as *hyperactive reflexes*.

Hypoesthesia. Decreased sensitivity of touch sensation on a particular area of skin. For example, a decreased ability to feel being touched (numbness) in an arm after a stroke would be described as a hypoesthesia in that arm. Hypoesthesia is a type of dysesthesia.

Hysterical seizures. Fake epileptic seizures. Also known as *pseudoseizures* and *psychogenic seizures*.

Idiopathic. Of unknown cause.

Innervating. Reference to nerve supply to a body part.

Intervertebral disc. Discs that separate and cushion the vertebrae.

Intracranial pressure (ICP). The pressure inside the skull. Increased ICP, as from a tumor or bleeding inside the head, can distort the brain with resulting unconsciousness and death.

Intraventricular hemorrhage (IVH). Bleeding inside a brain ventricle. IVH is most commonly seen in premature infants, but can also result from head trauma.

Laminectomy. Surgery to remove of a part of a vertebra known as its lamina. Laminectomies are done to relieve pressure on spinal nerve roots that often results from a herniated nucleus pulposus or arthritic spurs.

Larynx. Voice box.

Lasègue's sign. See *straight leg raising test*.

Lesions. Abnormalities.

Magnetic resonance imaging (MRI). Method of producing pictures of internal body structures using magnetic fields and radiofrequency fields. MRIs do not utilize x-rays or other radiation.

Malignant. Cancerous.

Masked facies. Mask-like appearance of the face—decreased facial expression.

Medulla. One of the parts of the brain stem.

Medulloblastoma. Cancerous tumor arising in the medulla of the brain.

Meninges. Membranes covering the brain and spinal cord. The thickest, outer meningeal membrane is called the dura mater. Surgical or other medical reports usually just list it as simply the “dura.”

Meningioma. Tumor of the meninges, rather than of the brain itself, which can, however, put dangerous pressure on the underlying brain tissue. Most meningiomas are benign.

Meningomyelocele. Congenital bag-like defect of the meninges and spinal cord.

Motor dysfunction. Abnormal motor function.

Motor function. Abilities related to movement, such as walking and use of the hands and arms.

Motor nerves. Nerves that stimulate muscle contraction and are therefore necessary for movement.

Muscle spasm. Involuntary contraction of a muscle that cannot be relaxed by an act of will.

Muscle tone. State of contraction of a muscle. A muscle with a complete absence of tone is flaccid, while the most extreme tone, hypertonicity, is a muscle spasm.

Myelin. The protective material that sheaths some nerve fibers. See *white matter*.

Myelography. X-ray technique for seeing pressure put on the spinal cord or nerve roots by herniated discs, arthritis or tumors. X-ray contrast material must be injected into the cerebrospinal fluid that surrounds the spinal cord and nerve roots.

Narcolepsy. Nervous system disorder associated with an irresistible desire to sleep. There are three important features of narcolepsy: (1) Cataplexy—loss of muscle tone, possibly with physical collapse, but without loss of consciousness; (2) Hypnagogic hallucinations—images that occur between waking and falling sleep; and (3) Sleep paralysis—a temporary feeling of being unable to move while falling asleep or just before awakening. There is no listing for narcolepsy, but if severe enough in disrupting daily activities narcolepsy could be considered by the SSA as being of equivalent severity to one of the epilepsy listings.

Nerve conduction study (NCS). Test that measures the ability of nerves to carry electrical impulses. Injured nerves may have a decreased nerve conduction velocity. Also known as *nerve conduction velocity (NCV)*.

Nerve root. The first part of a nerve as it is formed from the spinal cord.

Neurological. Pertaining to the nervous system.

Neuron. Nervous system cell.

Neuropathy. Any disease of peripheral nerves. Peripheral nerves are those connecting the spinal cord to the various organs and tissues of the body. There are many possible causes of neuropathy including drugs, diabetes mellitus, vitamin deficiencies and kidney disease. Neuropathy is best demonstrated by weakness, decreased reflexes, loss of sensation and decreased nerve conduction velocity (NCV). Motor neuropathy means affecting the motor nerves, while sensory neuropathy means affecting the sensory nerves. Not every type of sensation need be affected for neuropathy to be present.

Neurotransmitter. Chemical that allows nerve cells to communicate with each other.

Nystagmus. Abnormal, rhythmic, oscillating movements of one or both eyes. The oscillations are usually horizontal in direction, but may be vertical.

Oligodendroglioma. Tumors arising from brain cells called oligodendroglia, usually occurring in the white matter of the brain.

Definitions (continued)

Optic atrophy. Degeneration of the optic nerve as a result of neurological disease, such as multiple sclerosis.

Optic nerve. Nerve carrying visual information from the eye.

Optic neuritis. Inflammation of the optic nerve.

Paralysis. Loss of muscle strength resulting from muscle or neurological disorders. Use of the word may mean either partial or complete paralysis, unless further clarified.

Paraplegia. Paralysis of the legs.

Paresis. Partial paralysis.

Peripheral neuropathy. See *neuropathy*.

Pituitary gland. Pea-sized gland that hangs from the bottom of the brain on a stalk and produces a wide range of hormones. Most pituitary tumors are benign types called adenomas.

Postictal. Occurring after an epileptic seizure.

Primary sarcomas. Cancers arising in connective tissue, such as blood vessels (hemangiosarcoma) or the myelin sheaths around nerves (schwannoma).

Proprioception. The position sense by which a person can position an arm or leg without looking at it, such as in normal walking.

Pseudoseizures. See *hysterical seizures*.

Psychogenic seizures. See *hysterical seizures*.

Quadriplegia. Paralysis of both arms and legs.

Radicular distribution. The specific body area served by a particular nerve root from the spinal cord.

Radicular signs. Neurological abnormalities in a limb that indicate irritation of a spinal nerve root innervating it. Radicular signs are decreased deep tendon reflexes, muscle weakness, pain and decreased sensation.

Radiculitis. Inflammation of a spinal nerve root.

Remission. Improvement in a disorder.

Rigidity. Stiffness and inflexibility of muscles.

Romberg's test (Romberg's sign). Test of ability to maintain balance while standing with feet close together, with eyes open or closed.

Seizures. Attacks of abnormal mental and/or physical states that are caused by disturbed electrical activity in the brain. The most common disorder producing seizure is epilepsy. Also see *convulsion*.

Sensory nerves. Nerves that transmit sensory information (touch, pain, cold and the like) from the body to the spinal cord and up to the brain.

Spasticity. Excessive involuntary muscle contraction that makes limbs stiff and movement uncoordinated, as in a *spastic gait*.

Sphincters. Small, circular muscles that control the size of an opening.

Spinal stenosis. Narrowing of the spinal canal, usually as a result of arthritis.

Spine. Bony vertebrae stacked on top of each other and separated by intervertebral discs that permit some degree of cushioning and flexibility. The seven vertebrae of the neck

(C1–C7) are called the cervical spine. The 12 vertebrae in the chest are the thoracic spine (T1–T12), while the five vertebrae in the lower back are known as the lumbar spine (L1–L5). Beneath the lumbar spine is the sacrum, which consists of a triangular piece of bone of sacral vertebrae fused together (S1–S4). At the end of the spinal column is the tail-bone (coccyx). The vertebrae forming the spine are overlaid and connected by many spinal muscles and ligaments. They also form small joints between each other called *facet joints*.

Station. The manner in which a person stands.

Steppage gait. Gait in which the foot tends to hang in a downward position due to foot-drop. Consequently, the affected leg is lifted high and carefully placed straight down without the normal push-off of the front of the foot and toes.

Straight leg raising (SLR) test. With the patient lying on the back, lifting the outstretched leg until complaint of pain. The SLR is used to detect pressure on spinal nerve roots as could be caused by an HNP, tumors, bones spurs and the like. In normal individuals, the leg can be lifted 80° or more without pain. An SLR test should not be considered positive if leg movement is limited by tight hamstring tendons behind the knee. Back pain shooting down the leg during SLR is stronger evidence of nerve root compression than back pain alone. Also known as *Lasègue's sign*.

Stroke. See *cerebrovascular accident*.

Tabes dorsalis. Disease of the spinal cord caused by syphilis.

Tandem gait. Ability to walk while placing one foot in front of the other. Tandem gait is a test of balance.

Transient ischemic attack (TIA). Decreased blood flow to a part of the brain that is not prolonged enough to cause permanent damage, as would be the case with stroke. The effects of a TIA depend on the size and location of the brain area affected and may produce numbness or weakness in an arm or leg. A TIA is a warning and it is important to quickly treat its cause to prevent a stroke.

Tremor. Involuntary trembling or shaking of a body part.

Ventricles (of brain). Cavities within the brain substance that hold cerebrospinal fluid. The largest are the *lateral ventricles*.

Ventriculoperitoneal shunt (VP shunt). A surgically placed tube running from one of the lateral ventricles of the brain, down through the neck to drain into the abdominal cavity. The shunt carries cerebrospinal fluid that can be absorbed through the peritoneal membrane lining the abdominal cavity. The purpose of a VP shunt is to decrease intracranial pressure, by removing excessive cerebrospinal fluid from the brain, as might be seen with hydrocephalus. The major possible complications are infection and blockage of the shunt. Some brain damage is inevitable with a VP shunt, since the tube has to be pushed down through the brain substance to reach the ventricle deep within the brain. As the number of complications requiring re-operation (shunt revisions) increases, so does the chance of more brain damage.

Definitions (continued)

Visual evoked responses (VER). Measurements and computer analysis of electrical brainwaves produced in response to looking at a test pattern of light. Tests the health of the brain pathways involved in vision. It is completely safe and harmless.

White matter. Nervous system tissue consisting of those nerve fibers normally covered with an insulating substance called myelin. Nerve fibers carry information, in contrast to nervous system cells (neurons) that process information. See also *gray matter*.

A. General Information

The nervous system consists of a central nervous system (CNS) and a peripheral nervous system (PNS). The central nervous system includes the brain and spinal cord, while the peripheral nervous system is made up of the nerve cell clusters (ganglia) and nerves that supply the limbs and various organs of the body. Peripheral sensory nerves are responsible for carrying information from the body to the spinal cord for transmission to the brain. Peripheral motor nerves carry impulses from the brain, down the spinal cord and then to the muscles and various other organs.

There is also an autonomic nervous system (ANS) that carries out nonconscious functions, including muscular stimulation and glandular secretions. For example, the muscles in the esophagus, stomach, iris of the eye and intestines contract and relax with an automatic rhythm that is not under conscious control. The autonomic nervous system can be further divided into the sympathetic and parasympathetic nervous systems. Actions of the sympathetic nervous system cause the contraction of muscles in arteries to increase blood pressure and cause the release of adrenal gland hormones to increase blood pressure and heart rate. Actions of the parasympathetic nervous system tend to decrease heart rate and blood pressure and are important in stimulating the digestive system. To put it in another way, the sympathetic nervous system is activated by fear and anger, while the parasympathetic nervous system has more of a vegetative function. However, this is a great simplification of what are actually complex interactions between the two systems.

There are a large number of diseases that can affect various parts of the nervous system. Vitamin deficiencies, infections, strokes, toxic substances, drugs, epilepsy, genetic disorders, benign and cancerous tumors, degenerative diseases and trauma can all take their toll on the nervous

system in different ways. However, the underlying common ground for disability determination is how a person's ability to function is affected. Strokes caused by untreated high blood pressure, as well as brain and spinal cord trauma resulting from motor vehicle accidents, are frequent causes of disability. Epilepsy is another common basis for allegations of disability. Numerous disability claims are also filed for infants with intraventricular hemorrhage. Serious malformations of the brain may occur in infants, but most result in death too soon for it to be worth filing a disability claim.

Some of the listings mention IQ scores. There are some acceptable, standardized IQ tests like the Wechsler Intelligence Scale for Children, (WISC) or the Wechsler Adults Intelligence Scale, (WAIS) that have more than one IQ score: verbal, performance and full-scale. Whenever there are such multiple scores, the SSA must use the lowest valid score in determining if a listing is satisfied. However, the SSA is under no obligation to use IQ scores that appear invalid for some reason, such as inadequate cooperation during testing or scores that don't match other facts about your life such as employment skills, education and daily activities. When IQ tests are given, they should be the WAIS, WISC or Stanford-Binet. In children too young for formal IQ testing, developmental testing can be done and the scores used by the SSA as equivalent to IQ score.

As with other types of impairments, fair and accurate disability determination involving disorders of the nervous system requires evaluation of the evidence by medical doctors or osteopaths.

Note: Technically, an upper extremity is the arm, forearm and hand. Similarly, a lower extremity is a thigh, leg and foot. However, the common meaning is that a lower extremity is a leg and an upper extremity an arm. For ease of reading in this chapter, an upper extremity may be referred to as an arm and a lower extremity as a leg.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussions of residual functional capacity do not apply to children.

1. Listing 11.02: Epilepsy—Convulsive (Grand Mal or Psychomotor) (Adults)

Epilepsy can refer to any of a large number of types of seizures that affect consciousness, emotions or sensation or produce convulsions. Epilepsy is associated with abnormal electrical activity in the brain and is not fully understood. What is known is that areas of electrical instability, known as irritative foci, can trigger the spread of electrical abnormality through parts or all of the brain. For example, brain injuries may result in epilepsy as a result of irritative foci developing in areas of brain damage. However, many cases of epilepsy are classified as idiopathic. With epilepsy, the SSA and many claimants often make mistakes during the process of disability determination. Epilepsy is medically complex and the paperwork needed to make an accurate disability determination can also be complicated. If you have epilepsy, it is important that you understand the various factors that can make the difference between allowance and denial, so that you can both make and defend your claim.

Individual variation in the nature and severity of seizures cannot be overemphasized. To cite rare cases as examples, there are people who have seizures only with certain kinds of music or certain frequencies of flashing lights. One particularly unusual patient described in the medical literature only had a seizure when touched on a small spot on one shoulder. That spot was found to send sensations to an area in the brain where a blood vessel malformation had developed. This lesion made the brain electrically unstable and a seizure started when it received sensory impulses from the spot of skin on the shoulder.

A grand mal seizure is the type of epileptic event that most people know. In this type of seizure, convulsions affect the whole body, the victim loses consciousness and collapses. Such individuals may have nervous system or mental abnormalities that come before a seizure (aura), loss of bowel and urinary sphincter control resulting in incontinence, tongue biting and a period of confusion when the seizure subsides. Under this listing the SSA is interested in major motor seizures; by far the most common type is grand mal epilepsy. The convulsions of major motor seizures are known as generalized tonic-clonic seizures, because they affect the whole body. During the tonic phase, muscles stiffen; during the clonic phase, muscles jerk. Motor seizures that involve tonic-clonic activity in only a part of the body, such as an arm, do not qualify under this listing.

The listing also mentions psychomotor seizures, which are most often associated with abnormal activity in one of the brain's temporal lobes. Psychomotor seizures are also called partial complex seizures. However, part A of the

listing requires loss of consciousness and convulsions, neither of which are associated with psychomotor seizures. Psychomotor seizures do involve alteration of consciousness and sometimes the performance of activities for which the patient later has no memory. The exact nature of the experience is highly individualized. Some psychomotor seizures are very brief, lasting only seconds, with rapid restoration of normal conscious awareness. Others may be more prolonged, lasting several minutes, and may be disruptive to a person's ability to perform normal daily activities. If you have such prolonged psychomotor seizures and otherwise satisfy the listing, the SSA should consider an allowance on the basis of having an impairment of equivalent severity to major motor seizures like grand mal epilepsy, even though you don't have convulsions or lose consciousness.

There is an international seizure classification, but the SSA is not so much interested in the exact diagnostic name of the seizure as whether or not it falls into the category of a convulsive major motor seizure (adult Listing 11.02 and child Listing 111.02) or a convulsive minor motor seizure (adult Listing 11.03 and child Listing 111.03). There are certain types of information that are vital to every epilepsy case evaluated by the SSA:

1. The SSA requires an exact description of the seizures by your treating doctor, not just a diagnostic name. Descriptions by friends and relatives are also helpful, but statements by the treating doctor are much more important. How long each manifestation of a seizure episode lasts is important. If you have epilepsy, it is quite possible that your doctor has never actually seen you have a seizure, so your doctor will describe to the SSA what you have said. The truth is that many treating doctors—even neurologists—often have very poor descriptions of a patient's seizures in their records. However, it is not only vital for good treatment but for disability purposes that your doctor include in your medical records a good description of your seizures. Therefore, if you are thinking of applying for disability, you should discuss your seizures thoroughly with your doctor and request that a detailed description be entered into your records. Also, when the SSA sends you forms to complete regarding your seizures, your description should not conflict with what you have told your doctor.
2. The SSA needs medical records from your treating doctor stating the number of epileptic seizures you are having. No doctor can competently treat epilepsy without knowing how many seizures are occurring. Otherwise, there is no way to make treatment decisions, such as trying changes in medication. Make sure that your doctor knows if you are having seizures. It often happens that a

claimant will tell the SSA that they are having numerous seizures, even several times a day and yet their medical records will not contain this information. It is difficult for the SSA to believe the number of seizures claimants allege they have, when their own doctor's records do not back up what they say. The SSA should also be able to distinguish between the number of seizures you have during the day and those you have at night, since they involve different parts of the listing.

3. The SSA requires a statement by your treating doctor saying whether you have been cooperative with anticonvulsant drug therapy for your epilepsy. If you are not cooperative, the exact reason should be specified by your doctor—such as mental illness or lack of money. If you cannot afford the cost of anticonvulsant drugs, you should not be held responsible for your inability to follow prescribed therapy. However, the SSA can still deny your claim if it finds you a free source for drugs that control your seizures.

The SSA frequently sees claimants who have both epilepsy and a mental disorder. If the epilepsy is under poor control because of the claimant's failure to follow prescribed therapy, the question arises as to what extent the mental disorder can be blamed for such noncompliance. If a claimant is competent enough to be denied benefits under the mental disorders listings, then he has the mental capacity to take anti-epileptic medication. Thus, noncompliance is no excuse.

On the other hand, if the mental disorder is so severe that the person can't take anti-epilepsy medication without supervision, then he should be allowed benefits under one of the mental listings, so that his failure to follow the prescribed therapy for epilepsy becomes a nonissue. Alcohol use and abuse is one of the major reasons adult claimants with epilepsy fail to qualify under this listing. Alcohol interferes with the effectiveness of the anticonvulsant drugs used to treat epilepsy; claimants abusing alcohol are considered not to be cooperating with prescribed therapy as required by the listing. In fact, use of any alcohol can interfere with treatment and disqualify such a claimant. Another reason that alcohol abusers are not qualified under this listing is that seizures caused by withdrawal from alcohol are not epilepsy and will not last the required 12 months if the claimant abstains from alcohol abuse.

4. The SSA requires objective information about whether you are cooperating with prescribed treatment regarding your epilepsy. One thing the SSA must do before you can be allowed under this listing is measure the levels of anticonvulsant drugs in your blood, if this has not been done recently by your treating doctor. If your blood lev-

els are within the therapeutic range, this is strong evidence that you are following prescribed treatment. If your levels are low, it is possible that you have a fast metabolism for some of the drugs, interference between drugs, or a problem absorbing your medication. The SSA can check this by asking you to sign a release for your pharmacy records. If you have been getting your drugs regularly, it is a reasonable presumption that you have been taking them. Of course, if your anticonvulsant drug levels are low, your treating doctor should have detected that fact and either increased your dose of medication or changed drugs. However, the SSA does not get involved in whether they think your doctor is giving you the right treatment. You will not be faulted even if the person in the SSA reviewing your claim personally thinks there is a better way to treat your epilepsy. In fact, it is common for the SSA to see claimants with uncontrolled epilepsy who are taking older anticonvulsant drugs and have never been switched to newer medications by their treating doctor. If you are one of these people, don't expect the SSA to tell you so—they can't interfere. If the SSA does deny your claim on the grounds that you could get better treatment than you are receiving, then whoever made your disability determination has personally added a requirement that is not in this listing or other federal regulations or laws. Remember, however, that "prescribed treatment" as used by the listing refers to treatment by a licensed medical doctor or osteopath. If you are under the treatment of some other kind of healthcare practitioner, the SSA will not consider you to be under prescribed treatment.

5. Measurement of the brain's electrical activity or electroencephalogram (EEG), is a standard part of the diagnosis and treatment of epilepsy of all types. The EEG will often be abnormal during a true epileptic seizure, the type of abnormality depending on the type of epilepsy. Grand mal epilepsy, for example, will produce high voltage spikes. So if a claimant happens to be undergoing an EEG when seeming to have a convulsive seizure and the EEG remains normal, they are not having a real seizure. However, such hysterical seizures can occur in patients who also have true epilepsy. Since hysterical seizures sometimes occur in people who also have real epilepsy, it can be difficult for the SSA to determine the number of true seizures.

Most real seizures do not conveniently occur during an EEG, but some degree of abnormal electrical activity on an EEG done between seizures adds weight to the legitimate diagnosis of epilepsy. On the other hand, it is very important to know that a normal EEG done between seizures does not rule out epilepsy, and the SSA should

not use the presence of a normal EEG done between seizures as an argument to deny your claim.

In summary, EEG results are helpful but are not diagnostic of epilepsy unless run during an actual seizure. A normal EEG during a “seizure” is strong evidence for hysterical seizures.

6. Any injuries sustained by the claimant during an epileptic seizure and his response to treatment.

Epilepsy claims are difficult for the SSA to evaluate. To make accurate determinations regarding epilepsy, detailed and high-quality information is needed. Unfortunately, such information is frequently not available from treating doctors.

a. Listing Level Severity

For your condition to be considered severe enough to meet this listing, you must provide documentation including a detailed description of a typical seizure and all associated factors such as aura and postictal manifestations. Your seizures must occur more often than once a month, in spite of at least three months of prescribed treatment. Additionally, you must satisfy Ⓐ or Ⓑ, below.

- Ⓐ Daytime seizures, consisting of convulsions and loss of consciousness. If major seizures occur more than once monthly, the SSA assumes that they interfere with your ability to carry out normal daily activities, making them sufficient for allowance.
- Ⓑ Nocturnal seizures with residual effects that significantly interfere with activity during the day. “Significantly interfere” means more than a slight disruption in ability to carry out normal daily activities. Excessive daytime sleepiness, inability to think clearly, excessive irritability or other emotional disturbances, are all examples of postictal residuals that can affect ability to function during the day. The difficulty the SSA frequently has regarding part Ⓑ is lack of documentation of postictal residuals in medical records. If you have nocturnal seizures with daytime residuals, try to discuss your problems with your treating doctor before you apply for disability. Ask that your doctor record your difficulties in your records.

b. Residual Functional Capacity

If you have had even one major epileptic seizure during the 12 months prior to the date of disability determination, you have a significant impairment that should receive environmental restrictions on an RFC. These restrictions are: No work in high places where you could fall in the event of seizures, no driving any kind of vehicle (cars, trucks or other heavy equipment) and no work around or using hazardous

machinery. Depending on the exact nature of the seizures, other restrictions also might be appropriate. The SSA does not give exertional restrictions for epilepsy—there are no limitations on the amount of weight you could lift or carry or in your ability to stand or walk.

2. Listing 111.02: Epilepsy—Major Motor Seizure Disorder (Children)

See comments under adult Listing 11.02. Also, children may have febrile seizures, occurring with high fever. Such seizures are not generally considered to be epilepsy, and improve without any treatment. Since febrile seizures are the most frequent type of seizures in children, the SSA also commonly encounters this type of seizure in child disability cases. The prognosis for febrile seizures is good and they usually cannot qualify as epilepsy under this listing. If febrile seizures have occurred along with epileptic seizures, the SSA should carefully distinguish the two different disorders.

Nothing in this listing should be taken to mean that a child requires an abnormal EEG for allowance.

a. Listing Level Severity

To meet the listing a child must satisfy Ⓐ or Ⓑ, below.

- Ⓐ In a child with an established seizure disorder, the occurrence of at least one major motor (convulsive) seizure per month despite at least three months of prescribed treatment, with 1 or 2.
 1. Daytime episodes (loss of consciousness and convulsive seizures). See part Ⓐ in adult Listing 11.02.
 2. Nocturnal episodes with residual effects that interfere with activity during the day. See part Ⓑ in adult Listing 11.02.
- Ⓑ In a child with an established seizure disorder, the occurrence of at least one major motor (convulsive) seizure in the year prior to application, despite at least three months of prescribed treatment.

Additionally, 1, 2, 3 or 4 must be present.

 1. IQ of 70 or less.
 2. Significant interference with communication due to a speech, hearing or visual defect. Concerning speech, the child would have to have a problem like dysarthria or stuttering that poses more than a mild problem in understanding the child's speech. If the child has a speech impairment, she should be evaluated by a speech pathologist. The SSA can arrange such testing, if it has not been done.

Concerning hearing, an ability to hear only sound of more than 40 decibels (dB) intensity or speech discrimination worse than 60% would almost certainly produce

the required significant communication problem. These numbers are offered only as guidelines; they are not official SSA policy regarding this listing.

Concerning vision, a visual acuity in the child's better eye somewhere in the 20/50 to 20/70 range would probably be needed to produce significant interference with communication. An acuity of 20/50 or worse in adults is considered significant in relation to a work environment, but that doesn't necessarily translate to a significant difficulty in a child's communication ability. Similarly, a child with one eye blind and the other normal would have no significant communication or developmental difficulties, although it would be a significant impairment in an adult because of visual field limitations relevant to certain kinds of work.

Chapter 17 offers much more information about evaluating hearing, speech and visual disorders in both adults and children. This information can be helpful in deciding if a child qualifies under part ②.

3. Significant mental disorder. This leaves a lot of room for medical judgment. To make this judgment, the child will need a formal evaluation for a mental disorder, which means a thorough mental status examination by a psychiatrist or psychologist. The SSA can arrange for this testing, if it has not been done. Chapter 27 contains information about the evaluation of mental disorders that can be useful in deciding if part ③ is satisfied.
4. Significant side effects of medications that interfere with major daily activities. Examples of possible side effects include nausea, dizziness, headaches, depression and sleepiness. The important thing about part ④ is that the child's symptoms and daily activities be clearly recorded by the parents (or other caregiver) so that the SSA can evaluate them. The observations of teachers, day care center workers, etc., can also be helpful. If the child's medication side effects are significant, it is reasonable for the SSA to ask if they have been reported to the treating doctor and what actions may have been taken by the doctor to correct them. If the child's parents say there is a problem but the child's medical records do not reflect their concern, it is quite possible the SSA would deny the child's claim.

Note: In sections 2 through 4 above, the term significant means more than mild or slight, which is a decision requiring medical judgment. These judgments must be made by a medical professional familiar with the disorder and how it is evaluated in both physical and mental terms.

3. Listing 11.03: Epilepsy—Nonconvulsive (Petit Mal, Psychomotor or Focal) (Adults)

See comments under Listing 11.02 regarding epilepsy in general and the type of documentation needed. This listing is for seizures that are not individually as severe as the major motor (convulsive) seizures described in Listing 11.02.

Petit mal seizures are genetically caused, brief seizures lasting up to about 30 seconds. They are also called absence seizures, because they appear to make the person mentally absent for a brief period of time with no other evidence of anything being wrong. A characteristic spike and wave pattern is seen on an EEG during such a seizure. During a petit mal seizure, the person suddenly has a blank expression and loses awareness of their surroundings even though they don't fall or convulse. Full awareness returns quickly after most petit mal seizures. Some patients with petit mal epilepsy have hundreds of seizures daily and these people are more likely to have significant after effects (postictal manifestations).

As described in the comments under Listing 11.02, most psychomotor seizures start in the temporal lobes (temporal lobe epilepsy). Focal seizures are those involving only a part of the body, such as the jerking of an arm.

After a minor motor (nonconvulsive) seizure, people may engage in unusual behavior. These behaviors could be almost anything, as long as they are obviously out of the normal social context. For example, one claimant during a psychomotor seizure would undress in public. There could be other aftereffects that are not unconventional behavior, but which cause interference with ability to go about daily activities, such as confusion, sleepiness or memory problems.

To qualify under this listing, claimants do not have to have convulsions affecting their whole body, fall down, bite their tongue, lose control of their urine or bowels or have other manifestations found in major motor seizures. But because minor motor seizures are not as severe as major motor seizures, they have to occur more frequently than the major seizures described under Listing 11.02.

a. Listing Level Severity

For your condition to be considered severe enough to meet this listing, you must provide documented data including a detailed description of a typical seizure pattern and anything else associated with a seizure. Your seizures must occur more frequently than once a week in spite of at least three months of prescribed treatment. You must experience either loss of consciousness or at least a change of consciousness. Additionally, you must have some aftereffect

that significantly interferes with your ability to perform activities during the day or your seizure must be followed by some kind of temporary unconventional behavior.

b. Residual Functional Capacity

All adult claimants who have had a significant number of minor motor seizures during the 12 months prior to the date of disability determination have a significant impairment that should receive some restrictions on an RFC. There is no exact number that would qualify; this is a matter of medical judgment based on the type and duration of seizures, along with the probability of complete seizure control at the time of disability determination.

Appropriate restrictions for seizures are: no work in high places without protection against falling, no driving any kind of vehicle (cars, trucks or other heavy equipment) and no work around hazardous machinery of any kind. Depending on the exact nature of the seizures, other restrictions also might be appropriate.

4. Listing 111.03: Epilepsy—Nonconvulsive (Children)

See comments under adult Listing 11.03 regarding description of minor motor seizures. Also see comments under Listing 11.02 regarding epilepsy in general and the type of documentation needed.

This listing for children is easier to meet than the corresponding one for adults (11.03), because it doesn't require interference with daily activities or unconventional behavior. However, in children, EEG evidence must support the abnormalities characteristic of the seizure, such as the spike and wave pattern seen in petit mal epilepsy. In addition to the minor motor (nonconvulsive) seizures mentioned under adult Listing 11.03 (petit mal, psychomotor or focal), children may also have myoclonic seizures that qualify as minor motor seizures under this listing.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have a minor motor seizure disorder with more than one minor motor seizure per week and with alteration of awareness or loss of consciousness. These incidences must occur despite at least three months of prescribed therapy.

5. Listing 11.04: Cerebrovascular Accidents (CVAs) (Adults)

Cerebrovascular accidents (CVAs)—strokes—are not only common, but increasing in the United States because of the growing numbers of people with poorly controlled high blood pressure. This is a tragedy, since high blood pressure is a treatable disorder. Some claimants have had single strokes, others multiple strokes. Multiple small strokes in the white matter of the brain are known as lacunar strokes.

There are numerous ways mistakes can be made in evaluating your claim based on a CVA. Therefore, some important issues need to be covered regarding this listing.

Because recovery from a stroke is highly unpredictable, the SSA requires that a disability determination be delayed until three months following the stroke. However, in cases of massive brain damage and coma, where there is no question that a claimant will be significantly crippled, the SSA could make an earlier determination. But these claims are the exception rather than the rule.

The effect of strokes depends on where in the brain they occur. CVAs affecting visual nerve pathways in the brain or affecting the visual cortex in the back of the brain can affect visual acuity or peripheral vision. Visual limitations that can result from strokes are discussed in detail in Chapter 17.

Strokes may also affect your ability to breathe, because of paralysis of the respiratory muscles between the ribs, or paralysis of the diaphragm. The diaphragm consists of right and left sheets of muscle between the chest and abdomen that move to assist breathing. Breathing disorders are discussed in Chapter 18. This is an area that can easily be overlooked after a CVA, both by treating doctors and the SSA.

Strokes in adults frequently involve branches of the middle cerebral artery and can damage brain areas important for sensation and movement. Therefore, many adults with CVAs applying for disability have some degree of paralysis, usually an arm and a leg. Strokes affect the side of the body opposite the side of the brain where the stroke occurred. For example a CVA in the right side of the brain often causes numbness and weakness of the left arm and left leg.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have had a cerebrovascular accident (CVA). Additionally, **A** or **B** must be satisfied more than three months after the CVA.

A Sensory or motor aphasia resulting in ineffective speech or communication. This concerns the fact that CVAs in

the left hemisphere of the brain may damage language centers and produce aphasia. Receptive aphasia involves knowing, while motor aphasia involves expression through writing or speaking. Motor aphasia is also commonly known as expressive aphasia. Various combinations of receptive and motor aphasia are possible, both regarding severity and specific type of aphasia. A complete (global) aphasia refers to a combination of both receptive and expressive aphasia.

Aphasias can be extremely specific. For example, a receptive aphasia may only involve the inability to understand written words even though they can be seen, inability to identify common objects by touch alone (tactile aphasia), inability to understand spoken words (auditory aphasia) or inability to name objects seen (optic aphasia). Expressive aphasias may involve inability to speak although one knows what to say or inability to write words although one knows what to write. CVAs can also interfere with speech communication by producing dysarthria.

Ⓑ Significant neurological abnormalities in two extremities (weakness, lack of coordination, etc.) that result in:

- persistent difficulty standing and walking, or
- persistent difficulty using the hands, including both gross and dexterous movements of the fingers.

Part Ⓑ involves motor function: the ability to move or coordinate movement. In addition to paralysis, stroke victims often have decreased sensation in the body parts affected—especially numbness—and such sensory abnormalities can also affect motor function. Additionally, lack of coordination in using the arms or hands can result in significant limitations even if there is no loss of strength. For example, loss of strength or coordination in the legs may lead to problems with balancing and walking. The “two extremities” that must be involved for part Ⓑ can be both arms, both legs or one arm and one leg combined. If your legs are involved, it is important to be aware that part Ⓑ of the listing does not require you to need an assistive device like a cane or crutch to walk. Some more specific considerations regarding your ability to use your arms and legs after a stroke are given in the following several paragraphs.

When a doctor examines you, he or she should carefully test the muscle strength in your lower extremities. The doctor should subjectively test major muscle groups in one leg by having you exert effort with various muscles and then comparing your strength to your other, normal leg. The doctor should also wrap a tape measure around each leg and measure muscle sizes at the thigh and calf. You might have some muscle atrophy from weakness and disuse. Your muscle tone should be noted by the doctor—are any muscles spastic or flaccid? Do you have enough strength in your thigh muscles

to arise from a squatting position? Is there enough strength in your calf muscles for you to lift yourself on your toes and walk that way? Are the muscles in the front of your leg strong enough for you to lift your foot and walk on your heels? There are also machines that can reliably measure the force exerted by various muscles. Unfortunately, most doctors don't have this equipment for exact testing of lower extremity muscle strength, nor is it required for the listing. The doctor should also test your ability to maintain balance by observing your tandem gait—how well you can walk placing one foot in front of the other.

Gross movements of the hands are the ability to handle larger objects in lifting, carrying and grasping. For example, grasping a doorknob or other object about the size of a tennis ball or picking up a chair would be a gross movement. Although not required by the listing, grip strength can easily be measured by squeezing a hand ergometer. Unfortunately, most doctors do not use such machines for exact testing. Dexterous movements are those that require more coordination and speed, such as manipulating small objects with good separate control of each individual finger. For instance, playing a musical instrument, sewing, typing, picking up coins and buttoning clothes are all dexterous movements. During physical examinations, you should be able to quickly and easily touch each of your fingertips to your thumb in rapid succession, if your dexterous abilities are intact. The doctor should also observe whether you have any tremors in your hands or arms.

b. Residual Functional Capacity

It is important that stroke cases not qualified under the listing receive careful RFCs that take into account all of the problems you may have after a CVA: muscle weakness, lack of coordination, difficulty with balance, difficulty reading or understanding the spoken word, memory or personality problems, etc. All of these factors can influence your ability to return to prior work or find other work. Whether you have enough lower extremity strength to stand six to eight hours daily is always an important question, because inability to do so will automatically reduce your RFC to no higher than sedentary work. If you have a weakened leg, take notes on how long you can stand, how far you can walk and what other difficulties you might have, like walking up steps. If you can walk a block, is it at a normal speed? Also, note limitations you have with your hands. If you have a weakened arm, what objects have you noticed are too heavy to grasp and lift? Can you button your shirt with the affected hand? Pick up coins? Insert a key in a lock? Do you have difficulty coordinating your affected arm and hand—for example, are you no longer able to play a musical instru-

ment or perform some other task requiring good control? Also, if you have a weak arm or leg, you might have difficulty using arm or leg controls on machinery. When the SSA asks about your symptoms, give them this information. Don't assume that your treating doctor knows all about your limitations. Have your doctor record your limitations in your medical records. If you are depressed or have other emotional problems associated with your stroke, the SSA should evaluate those difficulties under the mental impairment listings (Chapter 27) and perhaps make a separate mental RFC determination.



If you can't stand and walk six to eight hours daily, your RFC cannot be higher than sedentary work. Sedentary work requires the good use of both upper extremities, including the ability to carry out fine manipulations such as the coordinated use of the hands and fingers in handling small objects. That means if you have any significant problems in doing fine manipulations with either hand, you cannot do even sedentary work and should have been allowed to meet the above listing. Such a difficulty with your hands wouldn't necessarily have to be neurological in origin.

Cerebral Aneurysms

A significant number (perhaps several percent) of people have aneurysms in the cerebral arteries supplying the brain. Rupture of a cerebral artery aneurysm is extremely dangerous and may result in death or crippling brain damage. In fact, a major cause of strokes is rupture of a cerebral artery aneurysm. The best hope is to detect large aneurysms and surgically clip them to prevent rupture. Claimants who have cerebral aneurysms that have not been operated on should never receive a residual functional capacity assessment (RFC) for more than light work, even if the aneurysm has not bled and there are no other abnormal findings. The SSA may decide that no restrictions are needed (no RFC) after a successful operation on a cerebral aneurysm, especially since some professional organizations of neurosurgeons have advised the SSA that no restriction is needed. However, cases should be considered on an individual basis—how big was the aneurysm, where was it located and has it bled before? Was previous bleeding related to some type of exertion? Is there untreated high blood pressure? These are the types of questions that should be asked and weighed by a doctor before a decision is made regarding whether an RFC should be given for an operated aneurysm.

6. Listing 11.05: Brain Tumors (Adults)

Brain tumors are always a serious matter, but particularly so when they are cancerous. Small tumors that are easily accessible and can be completely removed with surgery or radiation have the best prognosis. Depending on the size and location of the tumor, the patient may have headaches, paralysis or personality changes even after treatment. For example, brain tumors in the brain stem are very difficult to reach surgically and may encroach on areas vital for the regulation of blood pressure, heart beat and breathing. Important nerve tracts also pass through the brain stem to and from the brain.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have brain tumors that satisfy ① or ②, below.

① Any of the following cancerous brain tumors are considered disabilities on the basis of diagnosis alone:

- grade III or IV astrocytomas (glioblastoma multiforme)
- medulloblastomas
- ependymoblastomas
- primary sarcomas.

Part ① is satisfied by the more cancerous and aggressive ("high grade") brain tumors. Astrocytomas are tumors arising from astrocytes and are also referred to as types of malignant glioma. Astrocytomas are graded by the degree of malignancy, from grade I to grade IV. The most cancerous astrocytomas (grades III and IV) also go by the name of glioblastoma multiforme. It is important to know that when a pathologist examines astrocytoma cells under a microscope, various areas of the tumor may have different grades of malignancy. For example, one area of the tumor may be grade II while another area may be grade III or IV. Such tumors are characterized by their highest grade of malignancy and should be so treated by the SSA. Therefore, if a tumor has a combination of grade II cells and grade III cells, then it should be considered grade III. This is to the advantage of the claimant in applying for disability and is also medically reasonable.

Other cancerous tumors that can qualify under part ① are medulloblastomas which occur in the brain stem, ependymoblastomas which arise from the cells lining the ventricles of the brain and connective tissue tumors called primary sarcomas. If you have any of the tumors mentioned under part ① of the listing, you are an automatic allowance. The diagnosis of most cancers, including brain tumors, is proven by biopsy. However, there may be unusual cases in which the presence of a highly can-

cerous brain tumor is obvious, as demonstrated by cerebral angiography and CT or MRI scans, but in which a biopsy cannot be done. In these cases, the SSA should not require biopsy evidence for allowance.



Allowance under part ④ only requires valid diagnosis of one of the mentioned brain tumors. Such automatic allowance is based on the poor prognosis accompanying these cancers. But for how long after diagnosis would you be an allowance? What if you are a fortunate person who had one of these tumors, but it was detected early and now you have no tumor because it was treated with radiation or removed surgically? Would you still be an allowance if you apply for disability six months later? A year later? To be consistent with the way the SSA treats other forms of cancer, they should consider you under a disability, continuing for three years after such time as there is no evidence of the tumor. This three years is given because of the high likelihood of recurrence; after three years without any sign of cancer, the SSA would consider you cured for purposes of disability determination. If the tumor recurred at any time later, you would be considered at listing level severity for at least another three years. The important point here is that you don't have to have evidence of cancer at the time you apply for disability in order to qualify under part ④. In fact, you could feel fine.

⑤ Astrocytomas (grades I and II), meningiomas, pituitary tumors, oligodendrogliomas, ependymomas, clivus chordomas and other benign tumors. Evaluate under Listing 11.02, 11.03, 11.04 ④ or ⑤ or 12.02. Part ⑤ involves brain tumors for which treatment is generally more effective. For this reason, such low-grade brain cancers (grade I and II astrocytomas) and benign tumors are also recognized by the listing as possible causes of disability, but are not automatic allowances based on diagnosis alone. If the tumor produces epilepsy then it would be evaluated under the seizure listings (11.02 or 11.03). Mental disorders resulting from brain tumors would be evaluated under the mental impairment listings (organic mental disorders, Listing 12.02, Chapter 27). If the brain tumor caused a stroke, the claim would be evaluated under Listing 11.04. Some tumors have to be evaluated under multiple listings.



Sometimes neurosurgeons who have performed brain surgery emphasize the surgical recovery of the patient and may write in a report "Doing well, with no evidence of recurrent tumor." These general statements do not mean that a claimant lacks nervous system or mental problems. For example, it is not uncommon for a family member to tell the SSA that a claimant had a marked personality change after brain surgery, even though the treating neurosurgeon's records suggest ever-

thing is fine. Before denying a claimant with a brain tumor it is important that the SSA has detailed information about the claimant's nervous system and mental condition even if the SSA must pay for the examinations.

b. Residual Functional Capacity

Considering the large number of possible complications from brain tumors, medical judgment must be applied on a case-by-case basis in order to determine the correct RFC. Mental and physical residual impairments must both be considered. For example, if epilepsy is a complication of the tumor, then the RFC considerations under Listing 11.02 would be appropriate. If the tumor was associated with a stroke or produced similar limitations, see the discussion of strokes and RFCs for strokes under Listing 11.04. A mental disorder might require a mental RFC as discussed under the listings dealing with mental orders (Chapter 27).

7. Listing 111.05: Brain Tumors (Children)

See comments under adult Listing 11.05.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have brain tumors that satisfy ④ or ⑤, below.

A. Any of the following cancerous brain tumors are allowances on the basis of diagnosis alone:

- grade III or IV astrocytomas (glioblastoma multiforme)
- medulloblastomas
- ependymoblastomas
- primary sarcomas
- brain stem gliomas.

These tumors have a poor prognosis and are automatic allowances based on diagnosis alone.

⑥ The SSA will evaluate other brain tumors under the criteria for the resulting neurological impairment. Part ⑥ could be any other type of brain tumor, such as those mentioned in part ⑤ of adult Listing 11.05. These are evaluated based on the impairment they produce. For example, if the tumor resulted in epilepsy then it would be evaluated under the seizure listings (11.02 or 11.03). Mental disorders resulting from brain tumors would be evaluated under the mental impairment listings (11.02 and following, Chapter 27). If the brain tumor caused a stroke, the claim would be evaluated under Listing 11.06. Some tumors have to be evaluated under multiple listings.

8. Listing 11.06: Parkinsonian Syndrome (Adults)

Parkinsonian syndrome is a disorder caused by a chemical abnormality in areas of the brain called the basal ganglia. The missing brain chemical is the neurotransmitter dopamine and treatment is aimed at replacement with levodopa (L-dopa) and sometimes other drugs. Some cases are so severe that drug therapy is not sufficiently effective and brain surgery with or without electrode implantation may be necessary for a person to function. The injection of donor brain cells has also been tried, but a completely satisfactory cure has not been achieved. Infection, chemicals and drugs can all damage the basal ganglia and result in parkinsonism at any age. The specific cause of parkinsonism occurring in older people is still under study.

Parkinsonism is characterized by rigidity, bradykinesia and resting tremors in the hands. These tremors disappear during sleep and also improve with movement. They are often called “pill-rolling” tremors, because the movements look like the person is rolling pills between their forefinger and thumb. Such tremors are worsened by emotion. A festinating gait and a masked facies may be present, as well as dysarthria. The loss of functional ability is the same as for a stroke. Therefore, the comments about part ⑥ of Listing 11.04 would also be appropriate here.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have parkinsonian syndrome with significant rigidity, bradykinesia or tremor in two extremities, either alone or in combination that results in:

- persistent difficulty standing and walking, or
- persistent difficulty using the hands, including both gross and dexterous movements of the fingers.

b. Residual Functional Capacity

Even if your case does not qualify under the listing, make sure you receive a careful RFC, taking into account all of the problems you may have: tremors, lack of coordination, difficulty with balance or walking or speaking clearly or emotional problems such as depression. All of these factors can influence your ability to return to prior work or find other work. Whether you are able to stand six to eight hours daily is always an important question, because inability to do so will automatically reduce your RFC to no higher than sedentary work. If you have difficulty standing, take notes on how long you can stand, how far you can walk and what other difficulties you might have, like walking up or down steps. If you can walk a block, is it at a normal speed or slow? Although parkinsonism doesn't af-

fect muscle strength itself, slowness and poor balance could affect the amount of weight you can lift and carry. Is there any specific information you can provide the SSA when asked about your symptoms? Also, make note of the limitations you have with your hands, such as from tremors. Can you button your shirt with the affected hand? Pick up coins? Insert a key in a lock? Do you have difficulty coordinating your affected arm and hand—for example, are you no longer able to use it to play a musical instrument or perform some other task requiring good control? Also, if you have a weak arm or leg, you might have difficulty using arm or leg controls on machinery. When the SSA asks about your symptoms, give them this information. Don't assume that your treating doctor knows all about limitations in your ability to carry out daily activities. Talk to your doctor about recording your limitations in your medical records.

If you have dysarthria, the SSA should not try to say you can do a job requiring frequent or clear speaking skills. If you are depressed or have other emotional problems in association with your parkinsonism, the SSA should evaluate those difficulties under the mental impairment listings and a separate mental RFC might be necessary (Chapter 27).



If you can't stand and walk six to eight hours daily, your RFC cannot be higher than sedentary work. Sedentary work requires the good use of both upper extremities, including the ability to carry out fine manipulations such as the coordinated use of the hands and fingers in handling small objects. That means if you have any significant problems in doing fine manipulations with either hand, you cannot do even sedentary work and should have been allowed to meet the above listing. Unless your resting tremor is very well controlled, the SSA should not consider you capable of fine manipulations with your hands. Such a difficulty with your hands wouldn't necessarily have to be neurological in origin.

9. Listing 11.06: Motor Dysfunction (Due To Any Neurological Disorder) (Children)

This listing applies to any type of nervous system impairment that decreases a child's motor function. Motor dysfunction could be related to weakness from paralysis, but can be caused by lack of coordination, poor balance, tremors, ataxia, spasticity, athetosis or abnormalities of sensation (such as numbness) that interfere with the ability to use the arms or legs.

The requirements of this listing are essentially the same as those for adults with loss of function due to a neurological disorder. See comments about adult Listing 11.04⑥.

Do not assume that the child's treating doctor necessarily knows all about the child's limitations regarding daily

activities, unless it has been brought to the doctor's attention. For example, an examining neurologist might find and write down in records that a child has a "weak grip" in one hand. Unless actual strength measurements have been made, it is hard for the SSA to interpret the statement regarding severity. But if the parent has detailed what things the child has difficulty doing, a more accurate disability determination can be made. Is the child unable to grasp and turn a door-knob with one hand, but able with the other? Is she unable to play ball because she can't hold a bat or throw a ball? Numerous examples could apply—the important thing is to make them specific for the SSA. If the treating doctor discusses the child's limitations in their medical records, it strengthens the credibility of the parent's statements about the child problems.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have persistent motor dysfunction that involves two extremities and that despite treatment interferes with the child's ability to carry out major activities appropriate for her age. The parent or other caregiver must pay close attention to what the child can or cannot do. That will help the SSA evaluate the child's ability to perform activities that are appropriate for her age. For an infant, the range of normal age-appropriate activity is not all that vast.

Additionally, the child's condition must satisfy ① or ②, below.

- ① Persistent difficulty standing and walking. An infant who is too young to walk can still be observed regarding crawling and moving the legs.
- ② Persistent difficulty using the hands, including both gross and dexterous movements of the fingers. An infant is not expected to have fine motor skills (dexterous movements) involving the fingers, but can still be observed reaching and grasping.

10. Listing 11.07: Cerebral Palsy (Adults)

Cerebral palsy (CP) is not a specific disease, but refers to any nervous system problem dating from the time of birth that is not progressive and results from damage to the developing brain. The kinds of things that can cause brain damage are varied and include infection, toxins, birth trauma, genetic defects and asphyxia. Cerebral palsy may involve either physical or mental abnormalities. CP can result in a wide range of neurological impairments, including epilepsy, mental retardation, paralysis (paraplegia, hemiplegia or quadriplegia), spasticity, ataxia and athetosis, as well as visual, hearing and speech problems. Additionally, mental problems such as emo-

tional instability, short attention span and hyperactivity may be present. These broad categories are given as examples, and it should not be assumed that CP involves all of them. For example, individuals with CP may have normal intelligence. Also, it should not be presumed that all CP results in marked impairment: some people are only mildly limited.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have cerebral palsy that satisfies ①, ②, ③ or ④, below.

- ① IQ of 70 or less.
- ② Abnormal behavior patterns, such as destructiveness or emotional instability. This leaves a lot of room for medical judgment. If there appears to be a significant mental problem, a formal evaluation including a thorough mental status examination by a psychiatrist or psychologist will be needed. The SSA can arrange for such testing, if it has not been done. Chapter 27 contains information about the evaluation of mental disorders that can be useful in deciding if part ② is satisfied.
- ③ Significant interference in communication due to speech, hearing or visual defect. Part ③ involves problems with speech, hearing or vision. Regarding speech disorders, there would have to be some problem like dysarthria or stuttering that poses more than a mild problem in understanding the person's speech. If you have a speech impairment, it should be evaluated by a speech pathologist. The SSA can arrange testing, if it has not been done. In hearing disorders, an ability to hear only sound of more than 40 decibels (dB) intensity or speech discrimination worse than 60% would almost certainly produce the required significant communication problem. These numbers are offered only as guidelines; they are not official SSA policy regarding this listing. Regarding vision, an acuity of 20/50 or worse in adults is considered significant. With these cautions in mind, Chapter 17 offers much more information about evaluating hearing, speech and visual disorders in both adults and children. This information can be helpful in deciding if you qualify under part ③.
- ④ Disorganization of motor function as described in Listing 11.04④. This requires the same functional loss as for a stroke.

b. Residual Functional Capacity

Considering the large number of possible complications with cerebral palsy, medical judgment must be applied on a case-by-case basis in order to determine the correct RFC. For example, if epilepsy is a complication of the CP, then

the RFC considerations under Listing 11.02 would be appropriate. If the CP is associated with paralysis, see the discussion of strokes and RFCs for strokes under Listing 11.04. Note that significant speech, hearing or visual problems would meet the listing, and if they are not significant (more than mild or slight), they would not be put on an RFC. Therefore, their consideration under RFC should not be an issue. Similarly, a significant mental problem would meet the listing and also would not be an issue for determining the RFC.

11. Listing 11.07: Cerebral Palsy (Children)

See the comments about the general nature of cerebral palsy under adult Listing 11.07.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have cerebral palsy that satisfies Ⓐ or Ⓑ, below.

- Ⓐ Motor dysfunction meeting the requirements of Listing 101.03 (Chapter 16) or 111.06.
- Ⓑ Less severe motor dysfunction (but more than slight). Additionally, 1, 2, 3 or 4 must be satisfied.
 1. IQ of 70 or less.
 2. Seizure disorder, with at least one major motor seizure in the year prior to application for disability.
 3. Significant interference with communication due to speech, hearing or visual defect. Regarding speech disorders, there would have to be some problem like dysarthria or stuttering that poses more than a mild problem in understanding the child's speech. If the child has a speech impairment, he should be evaluated by a speech pathologist. The SSA can arrange such testing, if it has not been done. In hearing disorders, an ability to hear only sound of more than 40 dB intensity or speech discrimination worse than 60% would almost certainly produce the required significant communication problem. These numbers are offered only as guidelines; they are not official SSA policy regarding this listing. Regarding vision, it would probably take a visual acuity in the better eye somewhere in the 20/50 to 20/70 range to produce significant interference with communication. An acuity of 20/50 or worse in adults is considered significant in relation to a work environment, but that doesn't necessarily translate to a significant difficulty in a child's communication ability. Similarly, a child with one eye blind and the other normal would have no significant communication or developmental difficulties, although it would be a significant impairment

in an adult because of visual field limitations relevant to certain kinds of work. With these cautions in mind, Chapter 17 offers much more information about evaluating hearing, speech and visual disorders in both adults and children.

- 4. Significant mental disorder. Part Ⓑ4 requires a significant mental disorder, which leaves a lot of room for medical judgment. To make this judgment, the child will need a formal evaluation for a mental disorder, which means a thorough mental status examination by a psychiatrist or psychologist. The SSA can arrange for such testing, if it has not been done. Chapter 27 contains information about the evaluation of mental disorders that can be useful in deciding if part Ⓑ4 is satisfied.

12. Listing 11.08: Spinal Cord or Nerve Root Disorders (Adults)

The spinal cord, protected by the spine, connects the brain to the rest of the body. It is only about the diameter of a pencil, which is remarkable considering the amount of information it must carry. Nerve roots branch in right and left pairs from the spinal cord at regular intervals and become peripheral nerves. The peripheral nerves carry impulses from the brain through the spinal cord to muscles, glands and other organs. Similarly, the peripheral nerves constantly transfer information about the state of the body's tissues back to the brain. Many factors can damage the spinal cord or the nerve roots near it: tumors, trauma, infection, neurological diseases, vitamin deficiencies, genetic or congenital malformations, toxic substances, bone pressure from spinal arthritis, herniated intervertebral discs, etc. Trauma from automobile and motorcycle accidents is the most common cause of severe spinal cord injury seen by the SSA.

Reference should be made to the comments about Listing 11.04Ⓑ to understand the requirements of this listing.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have spinal cord or nerve root lesions, due to any cause, with disorganization of motor function as described in Listing 11.04Ⓑ.

b. Residual Functional Capacity

If you have a spinal cord injury or other disorder that doesn't qualify under the above listing, the SSA should carefully consider your degree of muscle weakness, lack of coordination, difficulty with balance, spasticity or other problems. All of these factors can influence your ability to return

to prior work or find other work. Whether you have enough lower extremity strength to stand six to eight hours daily is always an important question, because inability to do so will automatically reduce your RFC to no higher than sedentary work. If you have weakened legs, take notes on how long you can stand, how far you can walk and what other difficulties you might have, like walking up steps. If you can walk a block, is it at a normal speed or slow? Also, make note of the limitations you have with your hands. If you have weakened arms, what objects have you noticed are too heavy to grasp and lift? Can you button your shirt with the affected hand? Pick up coins? Insert a key in a lock? Do you have difficulty coordinating your affected arm and hand—for example, can you no longer use it to play a musical instrument or do some other task requiring good control? Also, if you have a weak arm or leg, you might have difficulty using arm or leg controls on machinery. When the SSA asks about your symptoms, give them this information. Don't assume that your treating doctor knows all about your limitations in carrying out your daily activities. Talk to your doctor about recording these limitations in your medical records.



As stated above, if you can't stand and walk six to eight hours daily, your RFC cannot be higher than sedentary work. Sedentary work requires the good use of both upper extremities, including the ability to carry out fine manipulations such as the coordinated use of the hands and fingers in handling small objects. That means if you have any significant problems in doing fine manipulations with either hand, you cannot do even sedentary work and should meet the above listing. Such a difficulty with your hands wouldn't necessarily have to be neurological in origin.

13. Listing 111.08: Meningomyelocele (and Related Disorders) (Children)

A meningomyelocele is a congenital bag-like defect of the spinal cord and membranes covering it. Meningomyeloceles may be associated with other nervous system disorders such as hydrocephalus and mental retardation. The listing also covers related disorders, meaning any kind of spinal cord defect present at birth could be considered under this listing.

a. Listing Level Severity

The child's condition must satisfy part Ⓐ, Ⓑ, Ⓒ or Ⓓ despite prescribed treatment.

- Ⓐ Motor dysfunction meeting the requirements of Listing 101.03 (Chapter 16) or 111.06.

- Ⓑ Less severe motor dysfunction (but more than slight). Additionally, 1 or 2 must be satisfied.

1. Urinary or fecal incontinence when inappropriate for age. This part concerns the fact that defects in the spinal cord can cause inability to control bowel or bladder. The SSA has no guidelines regarding whether incontinence must be complete or partial or how frequently it must occur. This is a matter of medical judgment for the person evaluating the child's claim, but it would have to be more than slight to be a meaningful limitation.

2. IQ of 70 or less.

- Ⓒ The involvement of four extremities. Involvement should be interpreted to include spasticity as well as weakness or paralysis.
- Ⓓ Noncompensated hydrocephalus producing interference with normal mental or nervous system development. This part deals with hydrocephalus in which cerebrospinal fluid pressure remains abnormally high inside the brain. It must be severe enough to interfere with the child's mental or neurological development, but the SSA has no policy guidelines regarding the severity of delayed development. The child's development can be measured with tests and the SSA should purchase such testing if it is not part of the child's medical records. It would be reasonable to assume that developmental delays would have to be more than slight, although this is not stated by the listing. Developmental testing is frequently purchased by the SSA.

14. Listing 11.09: Multiple Sclerosis (Adults)

Multiple sclerosis (MS) is a nervous system disease of unknown cause. It is one of the demyelinating disorders one of the, which are diseases affecting the insulating covering of nerves called myelin sheaths. Multiple sclerosis is an unpredictable disease characterized by periods of setbacks and improvement. Along with fluctuation in severity, there may also be an underlying chronic component of the disease that grows more severe over time. Therefore, the evaluation of multiple sclerosis must take into account the frequency of flare-ups, the length of remissions and the severity of any permanent residual impairment. Patients with multiple sclerosis may have pain, visual loss, fatigue, weakness, abnormalities of sensation, spasticity, lack of coordination, bowel or bladder dysfunction, sexual dysfunction or mental disturbances like anxiety or depression. Fatigue is especially common. There is no one drug that can effectively treat MS and there is no cure. Various medications and other treatments must be adjusted to the needs of the particular patient.

a. Listing Level Severity

For your condition to be severe enough to meet the listing for multiple sclerosis, you must have Ⓐ, Ⓑ or Ⓒ, below.

- Ⓐ Disorganization of motor function as described in Listing 11.04Ⓑ.
- Ⓑ Visual or mental impairment as described under the criteria in Listings 2.02, 2.03, 2.04 or 12.02 (see Chapters 17 and 27). Part Ⓑ deals with the fact that multiple sclerosis can result in visual loss. When MS attacks an optic nerve, the resulting optic neuritis can then lead to optic atrophy and visual loss. When looking in the eyes of a patient with multiple sclerosis, an examining doctor may be able to see optic atrophy, if it is not early. One or both eyes could be affected. Visual evoked responses (VER) should be abnormal when MS has significantly affected the optic nerve, even if a doctor cannot see abnormality in the optic nerve. The SSA should take into account the fact that visual acuity can wax and wane in multiple sclerosis patients and may become worse with certain types of visual activity like reading or close work. Reference should be made to the visual listings (Chapter 17) for more information about evaluating visual impairments.

This part also recognizes that MS can result in various mental disturbances, because of its effect on the brain. With the advent of magnetic resonance imaging (MRI) scans, the diagnosis of MS has become much easier by revealing the white matter lesions in the brain that are characteristic of this disorder. However, there are no absolutely diagnostic tests available for multiple sclerosis. If there is mental impairment, evaluation would be done under Listing 12.02 (“Organic Mental Disorders,” Chapter 27).

- Ⓒ Substantial, increasing muscle weakness with repetitive exercise, as demonstrated on physical examination by a doctor. The weakness must be related to areas of the brain known to be involved with multiple sclerosis and must be “reproducible” between physical examinations. This part is meant to identify those claimants with MS who have increasing weakness with exercise that is not detectable during the usual resting physical examination. The patient must meet all the following criteria:
 1. A documented diagnosis of multiple sclerosis.
 2. A description of fatigue considered to be characteristic of multiple sclerosis.
 3. Evidence that the claimant actually becomes fatigued.

The evaluation of the severity of the impairment must consider the degree of exercise and the degree of the resulting muscle weakness. In actual disability cases this part is basically useless. First, examining doctors, including neurologists, almost never test for increasing weak-

ness with exercise over a period of time. Secondly, the SSA has never set any test standards for what qualifies as increasing muscle weakness. Finally, it is almost impossible to tell from MRI or other scans or tests exactly what part of the body will be weak as a result of multiple sclerosis. Also, according to the SSA, this part is only to be used to evaluate increased weakness with exercise when it does not exist at rest. If there is resting weakness, part Ⓐ should be applied.

b. Residual Functional Capacity

The same considerations discussed under Listing 11.04 apply here, except for the comments about cerebral aneurysms. Also see the discussion of mental RFC under Listing 12.02 (Chapter 27) or visual RFCs (Chapter 17), as appropriate.

15. Listing 11.09: Communication Impairment (Children)

This listing concerns communication difficulties associated with documented nervous system disorders such as cerebral palsy. This listing does not apply to difficulties in communication that arise from a mental disorder. Communication includes the ability to speak, hear and understand speech. The SSA states that documentation of the child’s problems must involve a thorough evaluation done near enough to the time of disability application that it is still valid. The evaluation must be done by qualified professionals as discussed under specific parts of the listing below.

a. Listing Level Severity

In order to be considered severe enough to meet the listing, you the child’s condition must match Ⓐ, Ⓑ or Ⓒ, below.

- Ⓐ Documented speech deficit which significantly affects the clarity and content of speech. This part involves speech deficits, such as dysarthria, that are best evaluated by speech therapists. Whether the speech deficit is significant is a matter of medical judgment by the person evaluating the child’s claim. If the child’s speech is more than slightly difficult to understand, allowance under part Ⓐ would be appropriate, provided that the content of speech is also significantly decreased from the normal level. Content refers to the quality of information conveyed by the speech, but the SSA offers no more specific guidance in this regard. If the child uses speech with words and meanings more characteristic of a younger child, then it could be argued that the content is affected.
- Ⓑ Documented comprehension deficit resulting in ineffective verbal communication for age. This part deals with

comprehension deficits severe enough to make it impossible for the child to engage in age-appropriate communication. Such deficits would arise from damage to the areas of the brain dealing with processing auditory information. These comprehension deficits related to neurological impairment would best be evaluated by a child psychiatrist or a child psychologist with special training in the medical aspects of such disorders.

- Ⓒ Impairment of hearing as described in Listing 102.08 ("Hearing Loss," Chapter 17).

16. Listing 11.10: Amyotrophic Lateral Sclerosis (Adults)

Amyotrophic lateral sclerosis (ALS) is nearly always fatal. About 5–10% of cases are genetic. There is also a more common sporadic form that may be genetic or viral in origin, but whose cause remains obscure. In rare instances, children may have ALS. ALS usually affects those who are middle-aged or older, more frequently men. There is no curative treatment or therapy that can stop the progression of the disease. ALS only affects nerve cells involved in motor activity, so that the afflicted person is able to think and feel sensations even though there is loss of motor function. While some authorities emphasize that thinking (cognition) is spared, others see common abnormal mental functions involving the frontal lobes of the brain. Some authorities describe a number of types of ALS, caused by specific genetic mutations. While these variants of ALS may differ somewhat in their neurological manifestations, advanced cases would all have the types of problems described by this listing. Muscles become progressively weaker and atrophy from this disease. Death most often results from respiratory failure, when the muscles needed for breathing are too weak to function.



ALS is usually a fatal disorder. In people under age 65, there is a 50% mortality in three years and only 20% survive over five years. Virtually all claimants with ALS can meet the listing requirements by the time that they are diagnosed. If you have ALS and are denied benefits, you should consider whether the SSA made an error, the diagnosis was wrong or that you will soon be allowed benefits.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match Ⓐ or Ⓑ, below.

- Ⓐ Significant bulbar signs. This means more than slight in severity. It is not necessary that all possible bulbar signs be present; one is sufficient. The SSA should also con-

sider that multiple mild bulbar signs could collectively be considered significant.

- Ⓑ Disorganization of motor function as described in Listing 11.04Ⓑ.

b. Residual Functional Capacity

The discussion of RFC under Listing 11.08 would also apply here. However, the SSA should be reluctant to give an RFC for ALS unless it is going to result in a medical-vocational allowance. (See Chapters 8 and 9 for more information on medical-vocational allowance.)

17. Listing 11.11: Poliomyelitis (Adults)

A highly contagious virus that enters the body through the mouth and the bloodstream through the small intestine causes poliomyelitis (popularly known as polio). The early infection does not cause symptoms, but in cases where the virus destroys the motor nerves in the spinal cord necessary for movement, paralysis follows. Since polio has nearly been eradicated from the planet, the SSA does not see active cases of this disorder. However, residual weakness to some degree sometimes appears in older claimants who were affected many years ago; these cases are not generally severe enough to qualify under the listing.

Also, there is a disorder known as post-polio syndrome that is not a new infection, but a worsening in people who had polio years ago. Apparently, in this disorder, there are some nerve cells that seemed to recover from the original infection, but later relapse into a damaged state. Post-polio syndrome can result in pain, weakness, fatigue and intolerance for cold. If sufficiently severe, impairment can be considered of equal severity to the requirements of this listing.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match Ⓐ, Ⓑ or Ⓒ, below.

- Ⓐ Persistent difficulty with swallowing or breathing. This is satisfied by bulbar signs of difficulty swallowing or breathing. Respiratory failure is a common cause of death in active polio.
- Ⓑ Unintelligible speech. This is bulbar signs severe enough to make speech unintelligible. Such an effect could result from involvement of the tongue, larynx, throat or other parts of the mouth.
- Ⓒ Disorganization of motor function as described in Listing 11.04Ⓑ.

b. Residual Functional Capacity

Most older claimants who have persistent residual effects of polio infection have some degree of muscle weakness in one leg. Also, weakness or other symptoms of post-polio syndrome can recur after apparent recovery from polio many years ago. When present, medical judgment should take these abnormalities into account in determining the RFC. The comments about RFC under Listing 11.08 would also be relevant here.

18. Listing 11.12: Myasthenia Gravis (Adults)

Myasthenia gravis is an immune disorder characterized by the production of antibodies that block nerve receptors in muscles. Weakness results from inability of the nervous system to activate various muscles. Since movement of any body structure requires muscular contraction, myasthenia can be quite devastating. A frequent cause of death is respiratory failure. The severity and prognosis of this disorder is highly variable. Some patients have minimal symptoms or other abnormalities that can be treated with drugs to improve the ability of the nervous system to stimulate muscles. Others have rapidly progressive disease that is difficult to control. In myasthenia, muscle strength may decrease with repeated activity of the muscles affected. It is also possible to have a limited form of myasthenia mainly affecting the muscles of the eyelids and sparing the rest of the body.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match **A** or **B**, below.

- A** Significant difficulty with speaking, swallowing or breathing while on prescribed therapy. Bulbar signs that are more than slight in severity satisfy this part. Since muscles fatigue rapidly in myasthenia, there may be an inability to reasonably sustain good speech. It is not necessary that all possible bulbar signs be present; one is sufficient. The SSA should also consider that multiple mild bulbar signs could collectively be considered significant. Because myasthenia might be greatly improved with treatment, there is an additional requirement that the abnormalities be present despite prescribed therapy.
- B** Significant muscle weakness in the arms or legs with repetitive activity against resistance and while on prescribed therapy. This part takes into account that the weakness in myasthenia gravis is progressive during use of muscles. Although increasing weakness occurs in a normal muscle as it is used, it is accelerated greatly in myasthenia. Therefore, it would not be reasonable for

the SSA to judge muscle strength without considering how fast strength decreases with repetitive use. Since myasthenia can often be improved with drugs, the abnormalities must be present despite treatment.

The SSA provides no specific guidelines to test for increasing muscle weakness. In the absence of specific objective test requirements by the SSA, the examining doctor's subjective opinion regarding increasing muscle weakness is acceptable. For example, the claimant could push against the examining doctor's opposing arm strength on multiple tries or the doctor could give an opinion about weakening grip strength with repeated squeezing. If the calves of the legs are affected, the claimant should be increasingly unable to raise himself on his heels. If the doctor can provide objective measurements, such as the claimant's grip strength in pounds of force on multiple tries, that information would be preferable, since it would clearly show the decline in strength with repeated effort.

b. Residual Functional Capacity

The comments about RFC under Listing 11.08 would also be relevant here. Additionally, the SSA should also take into account the easy fatigability of your muscles. When you are carrying out activities, take careful note of the duration of the activity or number of repetitions that weaken you—whether it is walking up steps, pushing, pulling, grasping something or speaking. The more specific information the SSA has, the more likely you are to get an accurate determination.

19. Listing 11.13: Muscular Dystrophy (Adults)

Muscular dystrophy is a group of hereditary disorders of muscle tissue, rather than of the nervous system. However, the functional loss is similar to that of neurological diseases and that is why they are considered in the nervous system listings. Electromyograms can be useful in establishing the presence of a muscular disorder, but are not used to diagnose muscular dystrophy. A detailed history and physical examination are most important for diagnostic and functional evaluation.

Evaluation of muscular dystrophy cases must take into account the specific type of disorder. Duchenne muscular dystrophy (pseudohypertrophic muscular dystrophy) is a rapidly progressive disease in young boys that quickly results in a waddling gait and then inability to walk. Limb-girdle muscular dystrophy may start at any age up to about 30 years and usually has slowly progressive involvement of the shoulder and pelvic muscles.

Fascioscapulohumeral muscular dystrophy has an onset up to about age 20 years and is manifested by a slowly progressive weakness in shoulder and facial muscles; the legs may also be involved, but complete inability to walk usually does not occur in most cases. There is also associated cardiomyopathy in most cases, although lifespan may be normal.

Myotonic dystrophy (also known as myotonia atrophica) is the most common type of muscular dystrophy seen in adults; it is characterized by progressive muscular weakness and a prolonged inability to relax a hand grip once started. Because of the difficulty relaxing muscles, activities can be greatly slowed even if strength is fairly intact. Myotonic dystrophy is frequently accompanied by abnormalities in other organs, such as the heart, eyes and endocrine system. Such multi-organ involvement frequently leads to death by middle age. Mental retardation is present in some cases when the onset of myotonic dystrophy is early in life; if so, evaluation under the mental disorder listings (Chapter 27) would be appropriate.

a. Listing Level Severity

Muscular dystrophy with disorganization of motor function as described in Listing 11.04[®].

b. Residual Functional Capacity

The discussion of RFC under Listing 11.08 would also apply here. In myotonic dystrophy it is important for the SSA to take into account that slowness in using the hands (releasing grip) can be greatly restrictive even when significant grip strength remains. A slow grip release is dangerous when operating heavy equipment or other forms of hazardous machinery.

20. Listing 11.14: Peripheral Neuropathies (Adults)

One of the most common causes of peripheral neuropathy is diabetes mellitus, which is considered under Listing 9.08 (Chapter 24). Another common neuropathy is carpal tunnel syndrome (CTS) caused by pressure on the median nerve in the wrist. The SSA often sees CTS in claimants who have performed jobs requiring repetitive wrist movement, such as in the chicken processing industry. CTS can often be markedly improved by a simple surgical decompression of the median nerve in the wrist and forgoing the activity that caused the pressure on the nerve. Some other cases of carpal tunnel syndrome—especially those resulting from inflammatory disorders like rheumatoid arthritis and those that have been ignored for years without treatment—may be much more difficult to treat.

Neuropathies can also be caused by toxic substances, drugs, infections, nutritional deficits such as insufficient vitamins (rare in the United States), diseases of the immune system, heredity, cancer, kidney failure, trauma, or they may be of unknown cause. The success of treatment depends on the cause. Neuropathy caused by kidney failure would be evaluated under the kidney impairment listings (Chapter 21).

Motor neuropathy can decrease strength in the arms and legs. Sensory neuropathy causing numbness or confusion about the position of the legs can make standing and walking difficult or interfere with ability to work with the hands. So, even though sensory neuropathy concerns sensation rather than strength, it can still interfere with motor function as required by the listing. Therefore, either sensory or motor neuropathy can qualify or a mixture of the two. Peripheral neuropathy is best demonstrated by weakness, decreased reflexes, loss of sensation and abnormal nerve conduction studies (NCS).

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have peripheral neuropathy with disorganization of motor function as described in Listing 11.04[®], despite prescribed therapy.

b. Residual Functional Capacity

The discussion of RFC under Listing 11.08 would also apply here.

21. Listing 11.16: Subacute Combined Spinal Cord Degeneration (Adults)

This listing refers to degeneration of the spinal cord as a result of vitamin B₁₂ deficiency. This is a problem rarely seen by the SSA. It is more likely in vegetarians, since vitamin B₁₂ does not exist in vegetables. Also, there are various medical disorders, like pernicious anemia, that involve the inability of the body to absorb vitamin B₁₂ from food that is eaten. These disorders include parasitic or bacterial infection in the small intestine or surgery on the stomach or small intestine. Vitamin B₁₂ is easily administered. All vegetarians have to do is swallow B₁₂ tablets for supplementation. People who can't absorb B₁₂ from their food because of gastrointestinal problems are easily treated with periodic injections of the vitamin.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have subacute combined cord degeneration that

produces disorganization of motor function as described in Listing 11.04[Ⓐ] or 11.15[Ⓑ], not significantly improved by prescribed treatment.

b. Residual Functional Capacity

The comments about RFC under Listing 11.08 would also be relevant here. Special attention should be given to restrictions from working at unprotected heights or under any other conditions requiring good balance.

22. Listing 11.17: Degenerative Brain and Spinal Cord Diseases (Adults)

This listing concerns all degenerative nervous system diseases that are not mentioned in other listings. The SSA specifically gives the examples of Huntington's chorea, Friedreich's ataxia and spinocerebellar degeneration.

Huntington's chorea is a slowly progressive degenerative brain disease caused by a defect in chromosome #4. Although rare cases can start in children, most begin after age 35. Magnetic resonance imaging (MRI) shows the characteristic shrinkage of a part of brain known as the caudate nucleus. Prominent features are dementia, chorea and a broad-based gait resulting from involvement of the cerebellum of the brain. Epileptic seizures may also be present. There is no cure and no effective treatment for Huntington's chorea. Death usually occurs 10–15 years after onset.

Friedreich's ataxia is a genetic disorder that usually manifests before age ten. It is a degenerative nervous system disease that may be accompanied by numerous abnormalities including unintelligible speech, nystagmus, cardiomyopathy, deformities of the spine and feet and difficulty walking. Intelligence is not affected. Most patients die from heart failure.

Spinocerebellar degeneration refers to any of several degenerative disorders of the nervous system that affect the spinal cord and cerebellum. Difficulty walking secondary to cerebellar damage is a principle feature of these disorders. In olivopontocerebellar atrophy, for example, there is an uncoordinated gait. Epileptic seizures, dysarthria and nystagmus may also be present. The nystagmus can interfere with visual acuity. If so, see the discussion of the visual impairment listings (Chapter 17).

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have [Ⓐ] or [Ⓑ], below.

[Ⓐ] Disorganization of motor function as described in Listing 11.04[Ⓐ] or Listing 11.15[Ⓑ]. **Note:** The SSA intends to eliminate reference to Listing 11.15[Ⓑ] as unnecessary.

[Ⓑ] Chronic brain syndrome. Evaluate under mental disorder Listing 12.02. Part [Ⓑ] refers evaluation of dementia or other mental disturbances resulting from degenerative brain disease to Listing 12.02 ("Organic Mental Disorders," Chapter 27).

c. Residual Functional Capacity

Disregarding the comments about cerebral aneurysms, the same considerations of RFC discussed under Listing 11.04 would apply here. Also see the discussion of mental RFC under Listing 12.02 (Chapter 27) or visual RFCs (Chapter 17), as appropriate.

23. Listing 11.18: Cerebral Trauma (Adults)

Cerebral trauma means brain damage from some physical force. Examples would be gunshot wounds to the head, getting hit in the head numerous times such as in boxing matches or other fights, getting hit in the head by heavy equipment or accidents with automobiles or motorcycles. The brain is an extremely delicate structure, softer than Jello, and any substantial blow to the head is likely to damage it.

Brain damage from trauma might be a slow process. It can be caused over time by tiny bleeding spots in the brains of boxers that increase in number with each blow to the head. Or it could result from driving a car without a seat belt or riding a motorcycle without a helmet, in which case the damage can be quick and catastrophic. The SSA sees numerous cases of accidental cerebral trauma.

There are no specific requirements for brain trauma that will result in allowance of disability benefits. Evaluation is done under whatever criteria apply to the complications in a claim, such as the presence of epilepsy, stroke or organic brain syndrome (Listing 12.02, Chapter 27). The SSA should not deny a claim involving severe brain trauma with the prediction that it will improve to a denial level severity within 12 months. Such predictions are unreliable. If there is any question about whether a brain trauma case will remain severe for 12 months, the SSA should not make any final determination for at least six months after the injury so that an accurate medical assessment can be done.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have brain trauma. Evaluate under the provisions of Listings for epilepsy (11.02, 11.03), stroke (11.04) or chronic brain syndrome (12.02).

b. Residual Functional Capacity

Disregarding the comments about cerebral aneurysms, the same considerations of RFC discussed under Listing 11.04 would also apply here. Also see the discussion of mental RFC under Listing 12.02 (Chapter 27) or epilepsy, as appropriate.

24. Listing 11.19: Syringomyelia (Adults)

Syringomyelia is a disease of unknown cause in which cavities replace parts of the spinal cord or brainstem. Severe neurological abnormalities can result, depending on the location and size of cavities. Arthritis can result from joint damage caused by lack of sensation. If arthritis is present, it should be evaluated under the musculoskeletal listings (Chapter 16).

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have Ⓐ or Ⓑ, below.

- Ⓐ Significant bulbar signs. This part is satisfied by bulbar signs that are more than slight in severity. It is not necessary for all possible bulbar signs to be present; one is sufficient. The SSA should also consider that multiple mild bulbar signs could collectively be considered significant.
- Ⓑ Disorganization of motor function as described in Listing 11.04Ⓑ.

b. Residual Functional Capacity

The discussion of RFC under Listing 11.08 would also apply here. ■

Chapter 27

Mental Disorders

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Affect. Emotion.

Agoraphobia. Irrational fear of leaving familiar surroundings, such as one's home.

Akinesia. Absent or decreased movement.

Anhedonia. Inability to experience pleasure.

Anorexia nervosa. A serious mental disorder, usually in women and characterized by the fear of excessive weight gain although the person is markedly underweight.

Anxiety. An uncomfortable emotional state with effects both on the mind and body, resulting from anticipation of real or imagined danger. In "free-floating" anxiety, the person is not aware of the object of danger. Physiological effects may include increased heart and respiration rates, sweating, weakness and trembling.

Apathy. Lack of interest; indifference.

Autism. A pervasive developmental disorder starting in early childhood and characterized by marked social and communication deficits.

Bipolar disorder. A psychotic mental disorder involving episodes of both mania and depression.

Blunt affect. Decreased emotion for what would be considered appropriate to a particular situation.

Bulimia. Eating disorder, usually in younger females, characterized by episodes of binge eating. Bulimics may engage in self-induced vomiting after eating or other extreme activities in an attempt to control their eating disorder.

Catatonia. A disorganized mental state ranging from stupor to agitation.

Circumstantial speech. The injection of an excessive number of irrelevant details into speech.

Cognitive functions. The rational thinking functions of the mind that are in conscious awareness, as opposed to affective (emotional) functions. A more complex definition of cognitive functions used by the SSA is: "Cognition involves the ability to learn, understand and solve problems through intuition, perception, auditory and visual sequencing, verbal and nonverbal reasoning and the application of acquired knowledge. It also involves the ability to retain and recall information, images, events and procedures during the process of thinking."

Compulsion. An irrationally repeated act or ritual that helps a person decrease anxiety.

Confabulation. Filling in memory gaps with false or irrelevant facts.

Cyclothymic syndrome. Alternating moods of hypomania and depression, more extreme than normal but less extreme than bipolar disorder.

Decompensation. Worsening of a mental disorder.

Delirium. A temporary condition in which there is gross loss of awareness of surroundings (severe clouding of consciousness), often involving incoherent speech, hallucinations, delusions, psychomotor agitation, memory loss, emotional disturbance and disturbed sleep.

Delusion. Beliefs held despite evidence or experience to the contrary.

Dementia. Loss of intellectual ability, judgment, abstract thinking and memory caused by organic brain damage. Personality changes may also be present but, unlike delirium, there is no clouding of consciousness regarding general awareness of surroundings.

Depression. Depressed mood, as in sadness or despair.

Development. The attainment of mental and physical skills.

Developmental milestones. The attainment of particular mental or motor skills at age-appropriate levels.

Disorientation. Loss of knowledge of time, person or place.

Down syndrome. Hereditary disorder involving the presence of an extra #21 chromosome in cells, associated with mental retardation and possible abnormalities in various organs such as the heart. Also known as *trisomy 21*.

Dyskinesia. Abnormal movements.

Elation. The abnormally elevated mood component of mania; also used synonymously with *mania*.

Emotional lability. Emotional instability.

Extrapyramidal side effects (EPS). Abnormalities sometimes caused by antipsychotic drugs, especially older ones. Features of EPS that may be present include restlessness with a constant urge to move (akathisia), tremors, muscle rigidity, abnormal gait and muscle spasms in the head and neck. The risk of developing EPS is minimized with the newer drugs used to treat psychotic disorders.

Factitious disorders. Disorders in which a person intentionally fakes symptoms, with no other aim than assuming the role of a patient. Factitious disorders should be distinguished from malingering, in which there is intentional faking of symptoms to obtain some other goal than being a patient, such as avoiding work or obtaining monetary benefits.

Fine motor function. Reference to ability to use small muscles in a coordinated way, especially the hands and individual fingers.

Flat affect. Absence of emotional responsiveness even when it would be appropriate.

Flight of ideas. Rapid succession of thoughts that are not logically connected.

Functional disorder. Disorder that has no organic basis. Also known as a *psychogenic disorder*.

Gross motor function. Reference to ability to use large muscles in a coordinated way, such as walking, pushing and pulling.

Hallucination. A false sensory experience—that is, when no sensory stimulus is present. Any of the senses can be involved.

Definitions (continued)

Hypomania. An expansive mood that is not severe enough to be mania and is not associated with psychotic features such as delusions and hallucinations. Hypomania is severe enough to be noticeable to other people.

Hysterical seizures. See *psychogenic seizures*.

Illogical thinking. Thoughts that do not follow a rational connection between cause and effect.

Illusion. A false interpretation of a real sensory experience. Should not be confused with delusion.

Impulse control. Ability to self-restrain inappropriate behavior.

Inappropriate affect. Emotion that is not appropriate to a particular situation, such as excessive sadness or laughter that would not be present in a normal person under the same circumstances.

Incoherence. Disorganized thought or language, to the point of making rational communication impossible. More extreme mental disorganization than illogical thinking.

Incoherent speech. Speech without meaning.

Judgment. Ability to make accurate decisions, determinations or courses of action appropriate to a particular situation.

Loosening of associations. An abnormal mental process whereby the logical connection between thoughts is lost. If loosening of associations is severe enough, it becomes incoherent.

Malingering. A conscious effort to fake an illness to obtain some goal (such as avoidance of work or obtaining monetary benefits) other than playing the role of a patient. Also see *fabricitious disorder*.

Mania. Abnormal mental condition associated with bipolar disorder and characterized by elation, hyperactivity, poor judgment and increased speed of thought and speech.

Mental retardation. A disorder characterized by a significantly subaverage general intellectual functioning with deficits in adaptive behavior, initially manifested during the developmental period (before age 22). Decreased intellectual functioning as measured by IQ is not mental retardation.

Mental status examination. Direct personal evaluation of a person's mental condition by a psychiatrist or psychologist for the purpose of determining mental health, particularly regarding possible abnormalities of behavior, affect, thought, memory orientation or contact with reality.

Mood. A persistent emotion that broadly affects mental experience. As used by the SSA in listings, mood is a prolonged emotion that colors the whole psychic life, generally involving either depression or elation.

Motor development. Motor function acquired by a child compared to that normally expected.

Motor dysfunction. Abnormal motor function.

Motor function. Abilities related to movement, such as walking and use of the hands and arms.

Motor skills. See *motor function*.

Neuroleptics. Drugs used to treat mental disorders.

Obsession. Involuntary repetitious thoughts. Obsessions can be about anything but typically involve things like aggression,

fear of contamination, religion, sex, physical illness and a need to be overly exact. Obsessions cause anxiety that results in compulsive behaviors for relief.

Organic brain syndrome (OBS). Mental abnormalities associated with physical brain damage.

Orientation. A person's knowledge of time, person and place.

Overt. Outward, observable.

Paranoid thinking. Structured delusions of persecution and suspiciousness.

Passive-aggressive. Disorder in which a person is aggressive against others by means of passivity, such as being stubborn or otherwise obstructing a relationship.

Perception. Any kind of sensory experience.

Phobia. A persistent irrational fear of—and a compelling desire to avoid—a specific object, activity or situation.

Poverty of speech. Abnormal decrease in speech activity.

Premorbid. Before the onset of an illness.

Pressure of speech. Abnormal increase in the speed and amount of speech.

Pseudoseizures. See *psychogenic seizures*.

Psychogenic seizures. Seizures of psychological origin rather than the brain dysfunction characteristic of true epilepsy. Also known as *pseudoseizures* and *hysterical seizures*.

Psychomotor agitation. State of abnormally increased thinking and increased physical activity.

Psychomotor retardation. State of abnormally slowed thinking and slowed physical activity.

Psychotic disorders. Disorders, such as schizophrenia and manic-depressive illness that result in gross loss of contact with reality. Hallucinations and delusions are usually prominent features.

Psychotropic medications. Drugs used to treat mental disorders.

Remission. Recovery from an illness to some degree (full or partial remission).

Serial sevens. A standard part of mental status examinations to test a person's concentration by asking them to subtract seven from 100 repetitively, such as 100, 93, 86, 79, 72 ... etc., until zero is reached. Many otherwise normal people can't do this task very well. A more reasonable test of concentration in most people is subtraction of serial fives.

Somatoform disorders. Disorders that involve physical symptoms that are actually of psychological origin.

Standard deviation. A statistical calculation expressing the amount of deviation of a value from average.

Structured settings. Highly supervised and controlled environments where individual responsibility, decision making and stress are minimized.

Tic. An involuntary, repetitive, rapid, purposeless movement. Tics are most often seen in the facial muscles, but may also involve muscles in other locations. Tics can be of physical cause, such as in Tourette's syndrome, or of psychological cause.

A. General Information—Adult Mental Disorders

The SSA Listings for mental disorders are arranged in eight diagnostic categories: organic mental disorders (12.02); schizophrenic, paranoid and other psychotic disorders (12.03); affective disorders (12.04); mental retardation and autism (12.05); anxiety-related disorders (12.06); somatoform disorders (12.07); personality disorders (12.08); and substance addiction disorders (12.09). One listing may contain the criteria for several different mental disorders that fall in a diagnostic category. For example, Listing 12.08 is used to evaluate more than one type of personality disorder. Except for Listings 12.05 and 12.09, part ① of each listing gives the diagnostic clinical criteria that must be present to establish the presence of a mental disorder. If the part ① criteria are met, consideration is then given to the functional restrictions in part ②. There are additional considerations (part ③ criteria) in Listings 12.03 and 12.06.

The structure of the listing for substance addiction disorders, Listing 12.09, is different from that for the other mental disorder listings. Listing 12.09 is a reference listing; that is, it only serves to refer evaluation of disorders resulting from substance addiction to other appropriate listings.

The criteria defining specific mental disorders considered by the SSA are essentially the same as those given in part ① of each listing. The criteria used by the SSA in disability determination are derived from the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association. However, the SSA criteria are interpretations of DSM criteria, rather than exact reproductions. The definitions of some specific mental disorder terms are given above.

1. Need for Medical Evidence

The existence of a mental disorder of the required duration must be established by medical evidence consisting of clinical signs, symptoms and/or laboratory or psychological test findings. These findings may be intermittent or persistent depending on the nature of the disorder. Clinical signs can be medically demonstrated and reflect specific abnormalities of behavior, affect, thought, memory orientation or contact with reality. These signs are typically assessed by a psychiatrist or psychologist and/or documented by psychological tests. Symptoms are complaints presented by the individual. Signs and symptoms generally cluster in ways characteristic of particular mental disorders. Both symptoms and signs that are part of any diagnosed mental disorder must be considered in evaluating severity.

2. Assessment of Severity

The severity of mental disorders for disability purposes is determined by the functional limitations imposed by the impairment. As previously mentioned, part ② or ③ of a listing gives the functional criteria needed to establish allowance-level severity. When a listing uses “marked” as a standard for measuring the degree of limitation, it means more than moderate, but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively. These functional limitations are determined by descriptions of restrictions of activities of daily living; social functioning; concentration, persistence or pace; and ability to tolerate increased mental demands associated with competitive work. These four areas are considered in more detail as follows:

1. *Activities of daily living* include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one’s grooming and hygiene, using telephones and directories, using a post office, etc. The quality of these activities is judged by the person’s independence, appropriateness and effectiveness in carrying them out. It is necessary to determine the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.
“Marked” does not define the number of activities that are restricted but the overall degree of restriction or combination of restrictions. For example, a person who is able to cook and clean might still have marked restrictions of daily activities if he is too fearful to leave the immediate environment of home and neighborhood, hampering his ability to obtain treatment.
2. *Social functioning* refers to a person’s capacity to interact appropriately and communicate effectively with others. Social functioning includes the ability to get along with others, for example, family members, friends, neighbors, grocery clerks, landlords and bus drivers. A history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships and social isolation may demonstrate impaired social functioning. Strength in social functioning may be documented by a person’s ability to initiate social contacts with others, communicate clearly with others, interact and actively participate in group activities. Cooperative behaviors, consideration for others, awareness of others’ feelings and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, re-

sponding appropriately to persons in authority, such as supervisors, or cooperative behaviors involving coworkers.

“Marked” does not define the number of areas in which social functioning is impaired, but the overall degree of interference in a particular area or combination of areas of functioning. For example, a person who is highly antagonistic, uncooperative or hostile but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence and pace* refers to the ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete tasks in everyday household routines. Deficiencies in concentration, persistence and pace are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing. However, mental status examination or psychological test data alone should not be used to describe concentration and sustained ability to adequately perform work-like tasks. On mental status examinations, concentration is assessed by tasks such as having the individual subtract serial sevens or serial threes from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits. In work evaluations, concentration, persistence and pace are assessed through such tasks as filing index cards, locating telephone numbers or disassembling and reassembling objects. Strengths and weaknesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task and the extent to which assistance is required to complete the task.
4. *Episodes of decompensation* are periods of temporary worsening of symptoms or signs accompanied by a loss of adaptive functioning: difficulties performing activities of daily living, maintaining social relationships or maintaining concentration, persistence or pace in the completion of tasks. Episodes of decompensation can be shown by a worsening of symptoms or signs that would ordinarily require increased treatment or change to a less stressful situation (or a combination of the two). Episodes of decompensation can be documented by medical records showing significant alteration in medication; or documentation of the need for a more structured psychological support system (for example, hospitalizations, placement in a halfway house, or a highly structured and

supervised household); or other relevant information in records about the existence, severity and duration of the episode.

The term “repeated episodes of decompensation, each of extended duration” in these listings means three episodes within one year, or an average of once every four months, each lasting for at least two weeks. If the claimant has experienced more frequent episodes of shorter duration or less frequent episodes of longer duration, the SSA must use medical judgment to determine if the episodes produce enough functional limitation to be considered equal in severity.

3. Documentation

The presence of a mental disorder should be documented primarily on the basis of reports from individual treating sources such as psychiatrists and psychologists and facilities such as hospitals and clinics. Adequate descriptions of functional limitations must be obtained from these or other sources, which may include programs and facilities where the individual has been observed over a considerable period of time.

Information from both medical and nonmedical sources may be used to obtain detailed descriptions of the claimant's activities of daily living, social functioning, concentration, persistence and pace, or ability to tolerate increased mental demands (stress). Programs such as community mental health centers, day care centers and sheltered workshops can provide this information. Others, including family members, who have knowledge of the claimant's functioning, can also provide it. In some cases, descriptions of activities of daily living or social functioning given by claimants or their treating sources might not have enough detail and/or may be in conflict with information in examinations or reports. The SSA should resolve any inconsistencies or gaps in information that may exist, in order to obtain a proper understanding of the claimant's functional restrictions. Usually, this is done by asking treating sources for clarification and/or sending the claimant for mental status examination by a psychologist or psychiatrist.

A person's level of functioning may vary greatly over time, so that information from one specific time can be misleading. It is vital to obtain evidence from relevant sources over a sufficiently long period before the date of disability determination, in order to establish the severity of a mental disorder. This evidence should include treatment notes, hospital discharge summaries and work evaluation or rehabilitation progress notes if these are available.

Some claimants may have attempted to work or may actually have worked during a period of time relevant to

their condition when applying for disability. This may have been an independent attempt at work or it may have been in conjunction with a community mental health or other sheltered program. Information concerning the individual's behavior during any attempt to work and the circumstances surrounding termination of the work effort are particularly useful in determining her ability or inability to function in a work setting.

The results of well-standardized psychological tests such as the Wechsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), the Rorschach and the Thematic Apperception Test (TAT) may be useful in establishing the existence of a mental disorder. For example, the WAIS is an IQ test useful in establishing subaverage intellectual functioning and mental retardation. The MMPI (Minnesota Multiphasic Personality Inventory) is a widely used test consisting of hundreds of questions to be answered "true" or "false." The MMPI supposedly measures a variety of personality traits and mental abnormalities. The Rorschach consists of a series of cards, each with an inkblot design; the subject tells the examiner what he or she sees in the card and explains what it was about the design that influenced their response. The Rorschach supposedly reveals unconscious personality traits. The Thematic Apperception Test (TAT) consists of a set of drawings of people engaged in various activities and the subject is asked to explain the activities. Supposedly, when the subject "explains" the pictures there is personal identification with the people in the images and the answers are therefore revealing about the subject's own personality. Neuropsychological tests, such as the Halstead-Reitan or the Luria-Nebraska batteries, can be useful in determining brain function deficiencies. They are particularly helpful in cases involving subtle findings such as might be seen in traumatic brain injury. In addition, observations of a claimant taking a standardized test can provide information about their ability regarding concentration, persistence and pace. Therefore, test results should include both the objective data and a narrative description of clinical findings. Narrative reports of intelligence testing should include a discussion of whether or not the IQ scores are considered valid and consistent with the claimant's developmental history and degree of functional restriction.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 70 and below are characteristic of approximately the lowest 2% of the general population. In instances where other IQ tests are used, it would be necessary to convert the IQ to the corresponding percentile rank in the

general population in order to determine the actual degree of impairment reflected by those IQ scores. In other words, if the score on the non-WAIS IQ test was 75 and characteristic of the lowest 2% of the general population, it would be considered by the SSA to be an IQ of 70. Some claimants may have neurological or communication disorders that prevent the use of a standard IQ test like the WAIS, or they may have a culture and background that is not principally English-speaking. In these cases, other IQ tests can be used, such as the Test of Nonverbal Intelligence, Third Edition (TONI-3), Leiter International Performance Scale-Revised (Leiter-R) or Peabody Picture Vocabulary Test (PPVT-III).

In cases where more than one IQ is customarily derived from the test administered—where, for example, verbal, performance and full-scale IQs are provided as on the WAIS—the lowest of these is used in conjunction with Listing 12.05.

In cases where the claimant is incapable of taking a standard intelligence test, the SSA should obtain medical reports specifically describing the level of intellectual, social and physical function. Actual observations by Social Security Administration or state agency personnel, reports from educational institutions and information furnished by public welfare agencies or other reliable objective sources should be considered as additional evidence.

Anxiety disorders involving phobias, panic disorders and post-traumatic stress disorder should be documented with at least one good description of a typical reaction. The description should include the nature, frequency and duration of any panic attacks or other reactions, what brings on the attacks, what makes them worse and what effect they have on the claimant's ability to function normally. If the claimant's treating doctor provides the description, the doctor should indicate what part of the description they personally observed.

4. Chronic Mental Impairments

Special problems are often involved in evaluating mental impairments in people who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Claimants with chronic psychotic disorders, such as chronic schizophrenia, commonly have their lives structured in such a way as to minimize stress and reduce their signs and symptoms. Such claimants may be much more impaired for work than their signs and symptoms would indicate. The results of a single examination might not adequately describe their sustained ability to function. Therefore, it is vital for the SSA to review all information relevant to the claimant's condition, especially at times of increased stress. It is mandatory for the SSA to

attempt to obtain adequate descriptive information from all sources that have treated the claimant either currently or in the time period relevant to the decision.

5. Effects of Structured Settings

Particularly in cases involving chronic mental disorders, symptoms might be controlled or lessened by psychosocial factors such as placement in a hospital, board-and-care facility or other environment that provides similar structure. Such highly structured and supportive settings may greatly reduce the mental demands placed on an individual. With lowered mental demands, outward signs and symptoms of the underlying mental disorder may be minimized. At the same time, however, the claimant's ability to function outside of such a structured and/or supportive setting may not have changed. An evaluation of claimants whose symptoms are controlled or lessened by psychosocial factors must consider their ability to function outside of such highly structured settings. (For these reasons the part ③ criteria were added to Listings 12.03 and 12.06.)

6. Effects of Medication

Attention must be given to the effect of medication on the claimant's signs, symptoms and ability to function. For example, psychotropic medications might control certain manifestations of a mental disorder, such as hallucinations, but not necessarily improve functional limitations. In cases where overt symptoms are lessened by medications, particular attention must be focused on the functional restrictions that may persist. These functional restrictions are also to be used as the measure of impairment severity. (See the part ③ criteria in Listings 12.03 and 12.06.)

The medicines used in the treatment of some mental illnesses may cause drowsiness, blunted emotions or extrapyramidal side effects. Side effects must be considered in evaluating overall impairment severity, including the assessment of residual functional capacity.

7. Effect of Treatment

It must be remembered that with adequate treatment some individuals suffering with chronic mental disorders are so much improved that they return to a nearly normal condition. Treatment of a mentally impaired person may or may not result in the ability to work. (See the part ③ criteria in Listings 12.03 and 12.06.)

B. General Information— Child Mental Disorders

The listings for mental disorders in children under age 18 are arranged in 11 diagnostic categories: Organic mental disorders (112.02); schizophrenic, delusional (paranoid), schizoaffective and other psychotic disorders (112.03); mood disorders (112.04); mental retardation (112.05); anxiety disorders (112.06); somatoform, eating and tic disorders (112.07); personality disorders (112.08); psychoactive substance dependence disorders (112.09); autistic disorder and other pervasive developmental disorders (112.10); attention deficit hyperactivity disorder (112.11); and developmental and emotional disorders of newborns and younger infants (112.12).

There are significant differences between the listings for adults and the listings for children. The presentation of mental disorders in children, particularly the very young, may be subtle and different from the signs and symptoms found in adults. The activities appropriate to children, such as learning, growing, playing, maturing and adjusting to school, are also different from the activities appropriate to the adult and vary widely in the different childhood stages of development.

Each listing begins with an introductory statement that describes the disorder or disorders addressed by the listing. This is followed (except in Listings 112.05 and 112.12) by medical findings (part ① criteria). If part ① criteria are satisfied, evaluation is then done for impairment-related functional limitations (part ② criteria). A child will meet the listing when the criteria of both parts ① and ② are satisfied.

The purpose of the criteria in part ① is to substantiate medically the presence of a particular mental disorder. Specific symptoms and signs under any of the child listings must have a reasonable relationship to the description of the mental disorder contained at the beginning of each listing.

The purpose of the part ② criteria is to describe impairment-related functional limitations which are applicable to children. Standardized tests of social development, rational thinking and adaptive behavior are frequently available and appropriate for the evaluation of children and included in the part ② functional parameters. The functional restrictions in part ② must be the result of the mental disorder which is manifested by the medical findings in part ①.

1. Need for Medical Evidence

The same comments as for adult mental disorders apply here.

2. Assessment of Severity

In childhood cases, as with adults, severity is measured according to the functional limitations imposed by the mental disorder. However, the range of functions normally expected of children varies for different ages. As previously mentioned, part ⑧ of a listing gives the functional criteria needed to establish allowance-level severity. The functional areas that the SSA considers in child claims are: Motor function; cognitive/communicative function; social function; personal function; and concentration, persistence or pace. In most functional areas, the listings have two alternative methods of documenting the required level of severity:

- use of standardized tests alone, where appropriate test instruments are available, or
- use of other medical findings.

The use of standardized tests is the preferred method of documentation if such tests are available. (See “Documentation,” below, for further explanation of these requirements.)

When “marked” is mentioned as the standard for measuring the degree of limitation it means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with the ability to function (based upon age-appropriate expectations) independently, appropriately, effectively and on a sustained basis. When standardized tests are used as the measure of a child’s functional abilities, a valid score that is two standard deviations below the norm for the test will be considered a marked restriction.

The following information will give you some idea of how the SSA looks at functional limitations imposed by mental disorders in different age groups under the listings.

Older infants and toddlers (ages one and two). In this age group, impairment severity is assessed in three areas.

Motor development. Much of what can be learned about mental function in these children comes from observation of the degree of development of fine and gross motor function. Developmental delay is best measured by medical examination and a good developmental history. This information should be available in the child’s medical records, supplemented by information from nonmedical sources, such as parents, who have observed the child and can provide historical information. Measurement of motor development can also be done by standardized testing. If the child has not achieved motor development generally acquired by

children no more than one-half the child’s age, the criteria of the listing are satisfied.

Cognitive/communicative function. Cognitive/communicative function is measured using one of several standardized infant test scales. Appropriate tests for the measure of such function are discussed in the documentation section below. For older infants and toddlers, disruption in communication, as measured by the capacity to use simple verbal and nonverbal means to communicate basic needs, may substitute for test scores.

Social function. Social function in older infants and toddlers is measured in terms of the development of relationships to people (e.g., bonding and stranger anxiety) and attachment to animate or inanimate objects. Standard tests of social maturity or alternative criteria can be used to describe marked impairment in socialization.

Preschool children (ages three, four and five). Four functional areas are used to measure severity.

Cognitive/communicative function. In the preschool years and beyond, cognitive function can be measured by standardized tests of intelligence, although the appropriate instrument may vary with age. A primary criterion for limited cognitive function is a valid verbal, performance or full-scale IQ of 70 or less. The listings also provide alternative criteria, consisting of tests of language development or bizarre speech patterns.

Social function. Social functioning refers to a child’s capacity to form and maintain relationships with parents, other adults and peers. Social functioning includes the ability to get along with others (family members, neighborhood friends, classmates, teachers). Impaired social functioning may be caused by inappropriate externalized actions, such as running away or physical aggression which is not self-injurious. Or there may be inappropriate internalized actions, such as social isolation, avoidance of interpersonal activities or mutism. Decreased social function severity must be documented in terms of intensity, frequency and duration and shown to be beyond what might be reasonably expected for the child’s age. Strength in social functioning may be documented by such things as the child’s ability to respond to and initiate social interaction with others, to sustain relationships and to participate in group activities. Cooperative behaviors, consideration for others, awareness of others’ feelings and social maturity, appropriate to a child’s age, also need to be considered. Social functioning in play and school may involve interactions with adults, including responding appropriately to persons in authority (e.g., teachers and coaches) or cooperative behaviors involving other children. Social functioning is observed not only at home but also in preschool programs.

Personal function. Personal functioning in preschool children pertains to self-care, that is, personal needs, health and safety. Examples include feeding, dressing, toileting and bathing; maintaining personal hygiene, proper nutrition, sleep and health habits; adhering to medication or therapy regimens; and following safety precautions. Development of self-care skills is measured in terms of the child's increasing ability to help himself or herself and to cooperate with others in taking care of these needs. Impaired ability in this area is manifested by failure to develop such skills, failure to use them or self-injurious actions. Personal function may be documented by a standardized test of adaptive behavior or by a careful description of the child's full range of self-care activities. These activities are often observed not only at home but also in preschool programs.

Concentration, persistence or pace. This function may be measured through observations of the child in the course of standardized testing and in the course of play. For example, can the child maintain attention and motivation to finish play or other tasks in a reasonable amount of time?

Primary school children (ages six through eleven). The measures of function here are similar to those for preschool-age children except that the tests used may be different and the capacity to function in the school setting is used as supplemental information. Standardized measures of academic achievement, such as the Wide Range Achievement Test-Revised or Peabody Individual Achievement Test, may be helpful in assessing cognitive impairment. Problems in social functioning, especially in the area of peer relationships, are often observed firsthand by teachers and school nurses. As described in the documentation section below, school records are an excellent source of information concerning function and standardized testing and should always be sought for school-age children.

Adolescents (ages 12 through 17). Functional criteria are like those for primary school children. Tests appropriate to adolescents should be used where indicated. Comparable findings to test results for showing disruption of social function must consider the capacity to form appropriate, stable and lasting relationships. If information is available about cooperative working relationships in school or at part-time or full-time work, or about the ability to work as a member of a group, this information should be considered when assessing the adolescent's social functioning. Markedly impoverished social contact, isolation, withdrawal and inappropriate or bizarre behavior under the stress of socializing with others also constitute findings comparable to test results. (Note that self-injurious actions are evaluated in the personal area of functioning.)

Personal functioning in adolescents pertains to self-care. It is measured in the same terms as for younger children, the focus, however, being on the adolescent's ability to take care of his or her own personal needs, health and safety without assistance. Impaired ability in this area is manifested by failure to take care of these needs or by self-injurious actions. This function may be documented by a standardized test of adaptive behavior or by careful descriptions of the full range of self-care activities.

3. Documentation

The presence of a mental disorder in a child must be documented on the basis of reports from acceptable sources of medical evidence. Descriptions of functional limitations may be available from these sources, either in the form of standardized test results or in other medical findings supplied by the sources or both. (Medical findings consist of symptoms, signs and laboratory findings.) Whenever possible, a medical sources findings should reflect their consideration of information from parents or others who are aware of the child's activities of daily living, social functioning and ability to adapt to different settings and expectations. The medical sources should also report to the SSA findings and observations on examination of the child, consistent with standard clinical practice. As necessary, information from nonmedical sources, such as parents, should be used to supplement the record of the child's functioning. This will allow the SSA to establish the consistency of the medical evidence and impairment severity over a period of time.

For some newborn and young infants, it may be very difficult to document the presence or severity of a mental disorder. Therefore, with the exception of some genetic diseases and catastrophic congenital abnormalities, it may be necessary for the SSA to defer making a disability decision until the child attains three months of age, in order to obtain adequate observation of behavior or emotions. This period could be extended in cases of premature infants, depending on the degree of prematurity and the adequacy of documentation of their developmental and emotional status.

For infants and toddlers, programs of early intervention involving occupational, physical and speech therapists, nurses, social workers and special educators, are a useful source of data. They can provide the developmental milestone evaluations and records on the fine and gross motor functioning of these children. This information is valuable and can complement the medical examination by a physician. A report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source is considered acceptable medical evidence rather than supple-

mental data. (See the discussion of acceptable medical sources in Chapter 5.)

In children with mental disorders, particularly those requiring special placement, school records are a useful source of data. Also, the required re-evaluations at specified time periods can provide the data needed to follow the severity of the condition over time.

In some cases where the treating sources lack expertise in dealing with mental disorders of children, it may be necessary to obtain evidence from a psychiatrist, psychologist or pediatrician with experience and skill in the diagnosis and treatment of mental disorders as they appear in children. In these cases, however, every reasonable effort must be made to obtain the records of the treating sources, since these records will help establish a longitudinal picture that cannot be established through a single purchased examination.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 70 and below are characteristic of approximately the lowest 2% of the general population. In instances where other IQ tests are used, it would be necessary to convert the IQ to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by those IQ scores. In other words, if the score on the non-WAIS test was 75 and characteristic of the lowest 2% of the general population, it would be considered by the SSA to be an IQ of 70. Some claimants may have neurological or communication disorders that prevent the use of a standard IQ test like the WAIS, or they may have a culture and background that is not principally English-speaking. In these cases, other IQ tests can be used, such as the Test of Nonverbal Intelligence, Third Edition (TONI-3), Leiter International Performance Scale-Revised (Leiter-R) or Peabody Picture Vocabulary Test (PPVT-III).

In cases where more than one IQ is customarily derived from the test administered, such as where verbal, performance and full-scale IQs are provided as on the WAIS, the lowest of these is used in conjunction with Listing 112.05.

IQ test results must also be sufficiently current for accurate assessment under 112.05. Generally, the results of IQ tests tend to stabilize by the age of 16. Therefore, IQ test results obtained at age 16 or older should be viewed as a valid indication of the child's current status, provided they are compatible with the child's current behavior. IQ test results obtained between ages seven and 16 should be considered current for four years when the tested IQ is less than 40, and for two years when the IQ is 40 or above. IQ test results obtained before age seven are current for two

years if the tested IQ is less than 40 and one year if at 40 or above.

Where reference is made to developmental milestones, these are the skills achieved by an infant or toddler in the motor and manipulative areas, in general understanding and social behavior, in self-feeding, dressing and toilet training and in language. The result is sometimes expressed as a developmental quotient (DQ), the relation between developmental age and chronological age. Such tests include, but are not limited to, the Cattell Infant Intelligence Scale, the Bayley Scales of Infant Development and the Revised Stanford-Binet.

Formal psychological tests of cognitive functioning are generally used for preschool children, for primary school children and for adolescents. Exceptions may be considered in the case of ethnic or cultural minorities where the native language or culture is not principally English-speaking. In such instances, psychological tests that are culture-free, such as the Leiter International Performance Scale or the Scale of Multi-Culture Pluralistic Assessment (SOMPA) may be substituted for the standardized tests described above. Any required tests must be administered in the child's principal language. When this is not possible, appropriate medical, historical, social and other information must be reviewed in arriving at a determination. Furthermore, in evaluating mental impairments in children from a different culture, the best indicator of severity is often the level of adaptive functioning and how the child performs activities of daily living and social functioning.

"Neuropsychological testing" refers to the administration of standardized tests that are reliable and valid with respect to assessing impairment in brain functioning. It is intended that the psychologist or psychiatrist using these tests will be able to evaluate the following functions: Attention/concentration, problem-solving, language, memory, motor, visual-motor and visual-perceptual, contribution of right and left brain function and general intelligence (if not previously obtained).

4. Effect of Hospitalization or Residential Placement

As with adults, children with mental disorders may be placed in a variety of structured settings outside the home as part of their treatment. Such settings include, but are not limited to, psychiatric hospitals, developmental disabilities facilities, residential treatment centers and schools, community-based group homes and workshop facilities. The reduced mental demands of such structured settings may decrease overt symptoms and superficially make the

child's level of adaptive functioning appear better than it is. Therefore, the capacity of the child to function outside highly structured settings must be considered in evaluating impairment severity. This is done by determining the degree to which the child can function (based upon age-appropriate expectations) independently, appropriately, effectively and on a sustained basis outside the highly structured setting.

On the other hand, there may be a variety of causes for placement of a child in a structured setting that may or may not be directly related to impairment severity and functional ability. Placement in a structured setting does not, in and of itself, guarantee a finding of disability. The severity of the impairment must be compared with the requirements of the appropriate listing.

5. Effects of Medication

The same comments as for adult mental disorders apply here.

C. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 12.02: Organic Mental Disorders (Adults)

Organic mental disorders are those caused by physical brain damage. Examples of causes include toxins, heavy metals like lead or mercury, degenerative brain diseases like Alzheimer's disease and Huntington's chorea, strokes, trauma, tumors, cerebrovascular disease, genetic or congenital brain deformities, drugs and many other diseases. Doctors frequently refer to organic mental disorders in general as organic brain syndrome (OBS). For adults, the SSA frequently uses tests of neurological and mental functioning (neuropsychological testing) like the Halstead-Reitan and Luria-Nebraska tests. These tests require psychologists or psychiatrists experienced in their use and interpretation.

It is important that family members and others in frequent contact with the claimant make accurate observations about how the claimant's daily activities are abnormal and that they give this information to the SSA. For example, it is an important observation that an adult claimant or older child gets lost traveling alone, since that can indicate disorientation and memory impairment. Family members may note a change in the claimant's mood, such as depression and withdrawal or unstable emotions like sudden crying. Such observations can help examining psychiatrists or psychologists and the SSA reach a more accurate evaluation of the severity of the organic mental disorder.

The manifestations of organic mental disorders depend on the cause, location and severity of the brain abnormalities, including the age of the patient. It is important to understand that a fall in IQ associated with organic brain damage, such as that caused by brain trauma from an automobile wreck, produces much more serious limitations than in a person who is born with the same low IQ. In other words, a person who is born with an IQ of 70 will be much more capable than a person with an IQ of 100 whose IQ falls to 70. The reason for this is that a fall in IQ in a previously normal person diminishes other capacities in addition to intellect.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests must demonstrate the presence of a specific organic factor causing the abnormal mental state and the loss of previously acquired functional abilities.

The required level of severity is met when both ④ and ⑤ are satisfied, or when the requirements in ⑥ are satisfied. Part ④ provides abnormalities that may be present in organic mental disorders. Parts ⑤ and ⑥ discuss the functional severity of the disorder—that is, how it limits the claimant.

④ Demonstration of a loss of specific thinking abilities or emotional changes and the medically documented persistence of at least one of the following:

1. Disorientation as to time and place.
2. Memory impairment, either short-term (involving an inability to learn new information), intermediate or long-term (involving an inability to remember information that was known sometime in the past).
3. Perceptual or thinking disturbances (for example, hallucinations, delusions).
4. Change in personality.
5. Disturbance in mood.

6. Emotional lability—such as explosive temper outbursts or sudden crying and impairment of your impulse control.
 7. Loss of measured intellectual ability of at least 15 IQ points from premorbid levels or an overall impairment index that clearly falls within the severely impaired range on neuropsychological testing—such as the Luria-Nebraska or Halstead-Reitan.
- ⓑ Demonstration of a loss of specific thinking abilities or emotional changes resulting in at least two of the following:
1. Marked restriction of activities of daily living.
 2. Marked difficulties in maintaining social functioning.
 3. Marked difficulties in maintaining concentration, persistence or pace; or
 4. Repeated episodes of decompensation, each of extended duration.
- ⓒ Medically documented history of a chronic organic mental disorder lasting at least two years that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently decreased by medication or psychosocial support and one of the following:
1. Repeated episodes of decompensation, each of extended duration; or
 2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
 3. A current history of inability to function outside a highly supportive living arrangement for one or more years with signs that you'll continue to need such an arrangement.

b. Residual Functional Capacity

Residual functional capacity must be determined on an individual basis, depending on the kinds of abnormalities and functional limitations present. If you have no coexisting physical disorder and are capable of at least unskilled work on a mental RFC, your claim will almost always be denied. In other words, your claim will be denied with mental RFCs for unskilled, semiskilled or skilled work. Even if you can't return to your prior job (if any), unskilled work requires no special training and there are many unskilled jobs the SSA can say you are capable of doing. If your mental RFC is for less than unskilled work, then the SSA can't find any jobs for you and you would be a medical-vocational allowance. However, there is usually little point in giving claimants mental RFCs showing abilities for less than unskilled work,

since that implies such a severe disorder that it would probably satisfy a listing. So, with a mental impairment alone, your chance of medical-vocational allowance based on your mental RFC is slim.

The situation is different if you have a significant physical impairment, in addition to a mental disorder. And, in fact, many claimants have both types. Then, in order to determine if you are a medical-vocational allowance, the SSA has to consider the combined effect of both your physical and mental RFCs to determine if you can return to your prior work, if any. If you can't do your prior work because of some physical or mental limitation, the question is then whether you can do other work. If you get a mental RFC, you have significant *nonexertional* limitations in the kind of work you can do—that is, limitations other than lifting, standing, walking, pushing or pulling. The presence of such nonexertional limitations means that the SSA can't apply the Medical-Vocational Rules in Appendix C as they are written. For one thing, your “work experience” skills in the tables of rules might be higher than your current skills, because of your mental disorder and it wouldn't be fair to apply the rules to you as they are written. On the other hand, the SSA still uses the Medical-Vocational Rules as a “framework,” which just means they can be applied more flexibly on an individual basis.

EXAMPLE: Considering physical RFC only—You are 55 years of age, did skilled work in the past and have at least a high school education. Because of arthritis in your back, the SSA gives you a physical RFC for light work with only occasional bending. You can't do your prior job because of the frequent bending required and your education is not enough to permit your direct entry into another kind of work without additional training. However, your work skills could be transferred to another kind of job. By referring to Table 2 of the Medical-Vocational Rules (in Appendix C), you can see that your claim would be denied under Rule 202.07.

Adding effects of mental RFC—Because of your mental disorder, your mental RFC states you have the various abilities needed for unskilled work, but no higher. Taking your mental RFC into account, it would be wrong for the SSA to deny your claim under Rule 202.07, because you can no longer do the skilled work specified by the rule. The rule that most closely resembles your situation is 202.04 and you would be considered disabled under this rule. So the mental RFC completely changes the outcome of the disability decision.

The most important things to remember about mental RFCs are the abilities necessary to perform unskilled work.

If you have a “marked” limitation in any of these abilities on your RFC, you should be granted an allowance, regardless of your age, education or work experience. Carefully review the mental abilities needed for unskilled work in Chapter 8, as well as other skill levels.

2. Listing 112.02: Organic Mental Disorders (Children)

See the comments under adult Listing 12.02. Children do not develop Alzheimer's disease or brain damage caused by fatty blockage of a cerebral artery, but, aside from these, the same kinds of things can happen to the brains of children as adults. However, young children have more adaptable brains than adults and can sometimes compensate better for traumatic brain injuries. Mental abnormalities in children must be interpreted in the context of their age. Between the ages of one and three years, developmental tests are particularly useful in children. For example, the Bayley Scales of Infant Development is frequently used by the SSA to obtain a developmental quotient (DQ), which is the developmental age rather than the actual (chronological) age of the child. After about age three years, formal IQ testing can be done for cognitive (conscious thinking) skills.

As it applies to primary school children, the intent of the functional criterion described in part ②2.d is to identify the child who cannot adequately function in primary school because of a mental impairment. Although grades and the need for special education placement are relevant factors that must be considered in reaching a decision under part ②2.d, they are not conclusive. There is too much variability from school district to school district in the expected level of grading and in the criteria for special education placement to justify reliance solely on these factors.

In adolescents, the intent of the functional criterion described in part ②2.d is the same as in primary school children. However, other evidence of this functional impairment may also be available, such as from evidence of the child's performance in work or work-like settings.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have abnormalities in perception, cognition, affect or behavior associated with dysfunction of the brain. The history and physical examination or laboratory tests, including psychological or neuropsychological tests, must show an organic cause for the abnormal mental state, as well as for any associated deficit or loss of specific cognitive abilities or affective changes or loss of previously acquired functional abilities.

The required level of severity is met when both ④ and ⑤ are satisfied.

④ Medically documented persistence of at least one of the following:

1. Developmental arrest, delay or regression.
2. Disorientation to time and place.
3. Memory impairment, either short-term (inability to learn new information), intermediate or long-term (inability to remember information that was known sometime in the past).
4. Perceptual or thinking disturbance, such as hallucinations, delusions, illusions or paranoid thinking.
5. Disturbance in personality, such as apathy or hostility.
6. Disturbance in mood, like mania and depression.
7. Emotional lability, such as sudden crying.
8. Impairment of impulse control, which is seen as disinhibited social behavior or explosive temper outbursts.
9. Impairment of cognitive function, as measured by clinically timely standardized psychological testing.
10. Disturbance of concentration, attention or judgment.

⑤ Select the appropriate age group under which to evaluate the severity of the impairment:

1. For older infants and toddlers (ages one or two) at least one of the following:
 - a. Gross or fine motor development at a level generally acquired by children no more than one-half the child's chronological age, documented by:
 - i. An appropriate standardized test.
 - ii. Other medical findings (see “Assessment of Severity,” above).
 - b. Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age, documented by at least one of the following:
 - i. An appropriate standardized test.
 - ii. Other medical findings of equivalent cognitive/communicative abnormality, such as the inability to use simple verbal or nonverbal behavior to communicate basic needs or concepts.
 - c. Social function at a level generally acquired by children no more than one-half the child's chronological age, documented by at least one of the following:
 - i. An appropriate standardized test.
 - ii. Other medical findings of an equivalent abnormality of social functioning, shown by a serious inability to achieve age-appropriate autonomy, as manifested by excessive clinging or extreme separation anxiety.

- d. Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by a, b or c, as measured by an appropriate standardized test or other appropriate medical findings.
- 2. For children (ages three through seventeen) at least two of the following:
 - a. Marked impairment in age-appropriate cognitive/communicative function, documented by medical findings (including consideration of historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized psychological tests or, for children under age six, by appropriate tests of language and communication.
 - b. Marked impairment in age-appropriate social functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized tests.
 - c. Marked impairment in age-appropriate personal functioning, documented by history and medical findings (including information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, appropriate standardized tests.
 - d. Marked difficulties in maintaining concentration, persistence or pace.

3. Listing 12.03: Schizophrenic, Paranoid and Other Psychotic Disorders (Adults)

Psychotic disorders involve a widespread disturbance in mental function with severe distortion of the ability to distinguish external reality from an abnormal mental reality.

The most serious and common psychotic disorder the SSA evaluates for disability is schizophrenia, an affliction affecting about 1% of the U.S. population, with a typical onset in the teenage years or early adulthood. However, some cases have an onset in childhood and rare cases can start in middle age or later. After many years of research, the cause of schizophrenia remains unknown, although there is no question it involves abnormalities in the structure and function of the brain. The newer drugs used to treat schizophrenia such as olanzapine (Zyprexa), risperidone (Risperdal)

and clozapine (Clozaril) decrease the activity of dopamine and serotonin neurotransmitter chemicals in the brain. They have fewer side effects than the older drugs and have greatly improved the treatment of people with schizophrenia.

Hallucinations, especially auditory hallucinations in the form of persecutory voices, are often present. Delusions are common, especially paranoid delusions that others are out to harm the person in some way. Thinking may be confused and extremely irrational. The types of abnormalities in schizophrenia and other psychotic disorders that are of interest to the SSA are given in part Ⓐ of the listing. Parts Ⓑ and Ⓒ are used to determine the overall functional severity of the psychotic disorder.

The psychotic symptoms, such as hallucinations and delusions, of an acute schizophrenic episode can be controlled in the majority of cases. However, it should be remembered that a treating psychiatrist's medical note that a schizophrenic patient is "doing well," "stable" or something similar, does not imply normality and is not sufficient for the SSA to determine that a claimant does not qualify under the listing.

People with chronic schizophrenia should be evaluated with great care; they may not be capable of meaningful work. Symptoms that appear absent or mild while the claimant is in a protected environment, such as a family member's household, may become much more severe when the claimant is put under psychological stress. This possibility is addressed by part Ⓓ. It is in these cases of chronic schizophrenics living in highly structured environments that psychiatrists and psychologists working for the SSA are particularly apt to make mistakes in thinking that a claimant is more capable than is actually the case. That is why it is so important that the medical records of these claimants be clearly documented with any episodes of decompensation when subjected to stresses outside of a protected environment. In this way, the SSA has actual examples of the claimant's inability to function in real work situations, rather than having to make a judgment without that information.

The various subtypes of schizophrenia are paranoid, disorganized, catatonic, residual and undifferentiated. There is also a schizophreniform disorder that is not as severe as schizophrenia and has a better prognosis for recovery of ability to function in a work-related and social environment.

It is important to understand that the suspiciousness and delusions of persecution that characterize paranoid thinking may be a part of schizophrenia or other psychotic disorders. However, paranoia can also be a part of nonpsychotic mental disorders, such as occurs in a paranoid personality disorder.

Psychotic mental illness known as schizoaffective disorder is also seen by the SSA. In schizoaffective disorder, there are mental abnormalities characteristic of schizophrenia and

also of mood (affective) disorders. There are other, atypical or more unusual types of psychotic disorders that could potentially qualify under this listing.

It cannot be too strongly emphasized that good medical records over the time of the claimant's psychotic disorder can be critical to the SSA's making an accurate determination. An appropriate determination is much more difficult if the only evidence the SSA can obtain is one mental status examination report since this represents only one small slice of time.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must be characterized by the onset of psychotic features with deterioration from your previous level of functioning. The required level of severity is met when both ④ and ⑤ are satisfied or when ⑥ is satisfied.

- ④ Medically documented persistence, either continuous or intermittent, of one or more of the following:
 1. Delusions or hallucinations.
 2. Catatonic or other grossly disorganized behavior.
 3. Incoherence, loosening of associations, illogical thinking or poverty of content of speech if associated with one of the following:
 - a. Blunt affect.
 - b. Flat affect.
 - c. Inappropriate affect.
 4. Emotional withdrawal and/or isolation.
- ⑤ Medically documented persistence, either continuous or intermittent of the abnormalities described in part A, resulting in at least two of the following:
 1. Marked restriction of activities of daily living.
 2. Marked difficulties in maintaining social functioning.
 3. Marked difficulties in maintaining concentration, persistence or pace; or
 4. Repeated episodes of decompensation, each of extended duration.
- ⑥ Medically documented history of a chronic schizophrenic, paranoid or other psychotic mental disorder of two years or more that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently decreased by medication or psychosocial support and one of the following:
 1. Repeated episodes of decompensation, each of extended duration; or
 2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause you to decompensate; or

3. A current history of one year or more of an inability to function outside a highly supportive living arrangement, with signs that you'll continue to need such an arrangement.

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here. Some additional observations specifically about schizophrenia are also appropriate.

Although some people with schizophrenia can be improved greatly with drugs, it is difficult to find someone with schizophrenia who does not have some significant residual abnormality in mental function. While the positive psychotic symptoms like hallucinations and delusions may respond to drug therapy, some degree of negative psychotic symptoms like blunted emotions, poor motivation and poor social skills are more difficult to improve and usually remain present to some degree.

If you have no significant abnormalities after treatment for schizophrenia, the accuracy of your diagnosis should be questioned. It is very difficult, if not impossible, to restore schizophrenics to complete normality. If schizophrenia is the correct diagnosis, then the SSA would almost never be justified in determining that a claimant had a mild (not severe) impairment. To the contrary, significant limitations are most likely present and require a mental RFC if the listing is not satisfied.

4. Listing 112.03: Schizophrenic, Delusional (Paranoid), Schizoaffective and Other Psychotic Disorders (Children)

See the comments under adult Listing 12.03.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, it must involve the onset of psychotic features, characterized by a marked disturbance of thinking, feeling and behavior, with deterioration from the child's previous level of functioning or failure to achieve the expected level of social functioning.

The required level of severity is met when both ④ and ⑤, below, are satisfied.

- ④ Medically documented persistence, for at least six months, either continuous or intermittent, of one or more of the following:
 1. Delusions or hallucinations.
 2. Catatonic, bizarre or other grossly disorganized behavior.

3. Incoherence, loosening of associations, illogical thinking or poverty of content of speech.
 4. Flat, blunt or inappropriate emotions.
 5. Emotional withdrawal, apathy or isolation.
- ⓑ For older infants and toddlers (ages one or two), impairment resulting in at least one of the appropriate age-group criteria in part ⓐ1 of Listing 112.02; or, for children (ages three to seventeen), resulting in at least two of the appropriate age-group criteria in part ⓐ2 of Listing 112.02.

5. Listing 12.04: Affective (Mood) Disorders (Adults)

Affective disorders involve abnormalities of mood, which is a persistent emotion that broadly affects mental experience. The two possible extremes of mood are depression or elation. In depression, a person may have the types of abnormalities listed in part ⓐ1 below. Abnormalities characteristic of manic syndrome associated with elation are given in part ⓐ2. The abnormalities of depression or mania can exist in various combinations. Part ⓐ of the listing concerns establishing the type of affective disorder that is present. Part ⓑ of the listing is used to establish functional severity.

In major depressive disorder, the main abnormality is depression that may involve a single episode or be recurrent. Treatment of major depression almost always requires the use of antidepressant drugs. If drug therapy fails, electroconvulsive therapy (ECT), involving an electrical shock to the brain, may be given to patients with strong psychotic features such as hallucinations and delusions.

In dysthymic disorder, a depressed mood is present most of the time but the abnormalities are much less severe than with major depression. While dysthymic disorder can affect social and occupational functioning, these claimants are rarely so mentally limited that they cannot perform some type of work. Antidepressant drugs may also be used to treat dysthymic disorder.

In bipolar disorder, there may have been a single episode of mania or a history of a mixture of major depression episodes and manic episodes. There are specific diagnostic categories for various combinations of depression and mania and their relative severity. Bipolar disorder is a serious mental illness and requires mood-stabilizing medications. The most frequently used drug used for long-term treatment of bipolar disorder is lithium carbonate. Valproic acid (Depakene) and carbamazepine (Tegretol) are also mood-stabilizing. Other potent anti-psychotic and tranquilizing drugs may be necessary to treat an acute episode of mania.

The SSA may look at blood levels of these drugs, if there is a question about compliance with prescribed therapy.

Cyclothymic syndrome refers to alternating moods of hypomania and depression, more extreme than normal but less extreme than bipolar disorder. The depression in cyclothymic disorder is not severe enough to be diagnosed major depression. While cyclothymic disorder can affect social and occupational functioning, these claimants are rarely so mentally limited that they cannot perform some type of work.

Major depression and bipolar disorder are the most frequent illnesses seen by the SSA that qualify under this listing. Disability evaluation can be complicated by the fact that some claimants with genuine mood disorders also abuse alcohol or illegal drugs. Such alcohol or drug abuse can ruin what otherwise might be effective treatment.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must be characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. The required level of severity is met when both ⓐ and ⓑ are satisfied, or when the requirements in part ⓒ are satisfied.

ⓐ Medically documented persistence, either continuous or intermittent, of 1, 2 or 3:

1. Depressive syndrome characterized by at least four of the following:
 - a. Anhedonia or pervasive loss of interest in almost all activities.
 - b. Appetite disturbance with change in weight.
 - c. Sleep disturbance.
 - d. Psychomotor agitation or retardation.
 - e. Decreased energy.
 - f. Feelings of guilt or worthlessness.
 - g. Difficulty concentrating or thinking.
 - h. Thoughts of suicide.
 - i. Hallucinations, delusions or paranoid thinking.
2. Manic syndrome characterized by at least three of the following:
 - a. Hyperactivity.
 - b. Pressure of speech.
 - c. Flight of ideas.
 - d. Inflated self-esteem.
 - e. Decreased need for sleep.
 - f. Easy distractibility.

g. Involvement in activities that have a high probability of painful consequences that are not recognized.

h. Hallucinations, delusions or paranoid thinking.

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes).

Ⓐ Medically documented persistence, either continuous or intermittent, of the abnormalities described in part Ⓐ, resulting in at least two of the following:

1. Marked restriction of activities of daily living.
2. Marked difficulties in maintaining social functioning.
3. Marked difficulties in maintaining concentration, persistence or pace; or
4. Repeated episodes of decompensation, each of extended duration.

Ⓑ Medically documented history of a chronic affective mental disorder lasting at least two years that has caused more than a minimal limitation of your ability to do basic work activities, with symptoms or signs currently decreased by medication or psychosocial support and one of the following:

1. Repeated episodes of decompensation, each of extended duration;
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause you to decompensate; or
3. A current history of one year or more of your inability to function outside a highly supportive living arrangement, with signs that you'll continue to need such an arrangement.

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here.

6. Listing 112.04: Affective (Mood) Disorders (Children)

See the comments under adult Listing 12.04.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, it must be characterized by a disturbance of mood (referring to a prolonged emotion that colors the whole psychic life, generally involving either depression or elation), accompanied by a full or partial manic or depressive

syndrome. The required level of severity is met when Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented persistence, either continuous or intermittent, of 1, 2 or 3:

1. Major depressive syndrome, characterized by at least five of the following, which must include either depressed or irritable mood (a) or markedly diminished interest or pleasure (b):

- a. Depressed or irritable mood.
- b. Markedly diminished interest or pleasure in almost all activities.
- c. Appetite or weight increase or decrease or failure to make expected weight gains.
- d. Sleep disturbance.
- e. Psychomotor agitation or retardation.
- f. Fatigue or loss of energy.
- g. Feelings of worthlessness or guilt.
- h. Difficulty thinking or concentrating.
- i. Suicidal thoughts or acts.
- j. Hallucinations, delusions or paranoid thinking.

2. Manic syndrome, characterized by elevated, expansive or irritable mood and at least three of the following:

- a. Increased activity or psychomotor agitation.
- b. Increased talkativeness or pressure of speech.
- c. Flight of ideas or subjectively experienced racing thoughts.
- d. Inflated self-esteem or grandiosity.
- e. Decreased need for sleep.
- f. Easy distractibility.
- g. Involvement in activities that have a high potential of painful consequences, which are not recognized.
- h. Hallucinations, delusions or paranoid thinking.

3. Bipolar or cyclothymic syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently or most recently characterized by the full or partial symptomatic picture of either or both syndromes).

Ⓑ For older infants and toddlers (ages one or two), impairment resulting in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02, for children (ages three to seventeen), resulting in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

7. Listing 12.05 Mental Retardation (Adults)

If you care for or represent someone who is mentally retarded, or who has below-average intelligence, it is extremely important that you understand the disability determination issues involved in the use of this listing. Although large numbers of claimants are evaluated for disability un-

der this listing, the SSA is prone to errors when evaluating such claims. A common mistake is diagnosing mental retardation on the basis of intelligence quotient (IQ) scores alone. A sub-average IQ—say an IQ of 70—is not considered to be mental retardation unless the individual has a loss of adaptive functions. The reason that adaptive functioning is important in addition to intellectual functioning is that claimants may differ greatly in their adaptive abilities despite having the same IQ. Ability to independently carry out daily activities and function socially are adaptations very much dependent on the type of environment in which a person lives. If she lacks proper types of training, emotional support and stimulation, a child can grow into an adult with an IQ of 70 who is highly limited in ability to adapt and live independently. Others with the same IQ can work and are able to achieve independence. Consequently, it is a serious mistake to diagnose mental retardation on the basis of IQ alone, unless it is less than 60 (see below).

Part ① is for claimants who are so severely retarded that they cannot even be given an IQ test. In these cases, low IQ and significantly decreased adaptive functioning are both obvious without formal testing.

Part ② applies to IQs below 60. Such an IQ is low enough that it is also reasonable to assume that there are severe deficits in adaptive functioning without requiring further documentation. In other words, it is assumed that the claimant is mentally retarded.

Part ③ requires subaverage intellectual function of IQ 60 through 70, and some other additional *distinctly different* significant impairment like arthritis or a separate mental disorder. The additional impairment can't be some limitation that results from the low IQ, because that would be “double-weighting” the impairment for disability determination and is prohibited by the SSA. Note that the additional impairment has to be work-related to have any meaning in disability determination. For example, baldness is not a significant impairment to the SSA, because it has no relationship to the ability to work. Remember, any disorder severe enough that it would require an RFC if rated alone is a significant work-related impairment. For instance, if a claimant had arthritis that would limit her to medium work on a physical RFC, that would be significant, as would be an anxiety disorder severe enough to require a mental RFC. That doesn't mean the SSA necessarily has to actually complete an RFC form to determine if the additional impairment is significant.

EXAMPLE: The SSA evaluator could determine that an IQ of 65 is valid and arthritis in the claimant is severe enough to require a physical RFC if considered alone. Therefore, the arthritis is a significant work-related

impairment and, combined with the IQ of 65, meets Listing 12.05C.

One of the most serious and frequent mistakes made by the SSA in part ③ is failing to properly take into account epilepsy as a significant impairment in addition to an IQ in the 60 through 70 range. People with subaverage IQs often have problems with epilepsy. Only one major seizure in the year prior to application for disability for epilepsy qualifies as a significant impairment.

Part ④ requires a *documented* subaverage IQ of 60 through 70 and marked deficits in adaptive functions (parts ④1-4) for the diagnosis of mental retardation to be valid.

Falls in IQ in adults are not mental retardation, but indicate some type of organic brain disorder. Such cases would be evaluated under Listing 12.02, and are much more limiting than the same IQ associated with mental retardation.

The Stanford-Binet test yields only one IQ score. The Wechsler Adult Intelligence Scale (WAIS) yields a performance IQ, verbal IQ and full-scale IQ. The IQ scores must be *valid*. IQ scores that are affected by lack of cooperation during testing, measured during acute psychosis or while the claimant is intoxicated with alcohol or other potent mind-altering drugs (legal or illegal) are not valid. The SSA may also suspect invalid IQ scores that are too low for a claimant's prior education or work experience. If there is more than one IQ score obtained as part of an IQ test, the SSA must use the *lowest* score. This works to the advantage of the claimant. When considering the validity of an IQ score, it is important to remember that IQ scores stabilize by about age 16.

Learning Disorders and Communication Disorders

Learning and communication disorders, which are rarely disabling, should not be confused with mental retardation. Reading disorder is a common type of learning disorder and there are several types of communication disorder. These disorders sometimes result in a low IQ score for a particular part of an IQ test, especially a low verbal IQ while the performance IQ is normal. However, these children or adults function fine in most aspects of their lives. Such low IQs associated with learning or communication disorders, rather than true subaverage intellectual functioning, *cannot* be used to satisfy this listing.

a. Listing Level Severity

For the claimant's condition to be severe enough to meet this listing, he or she must have mental retardation, that is, a significantly sub-average general intellectual functioning with deficits in adaptive functioning that initially manifested during the developmental period—in other words, the evidence demonstrates or supports the onset of the impairment before age 22. (**Note:** The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.)

The required level of severity for this disorder is met when the requirements in part ①, ②, ③ or ④ are satisfied.

- ① Mental incapacity evidenced by dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded.
- ② A valid verbal, performance or full-scale IQ of 59 or less.
- ③ A valid verbal, performance or full-scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant work-related limitation of function.
- ④ A valid verbal, performance or full-scale IQ of 60 through 70, resulting in two of the following:
 1. Marked restriction of activities of daily living.
 2. Marked difficulties in maintaining social functioning.
 3. Marked difficulties in maintaining concentration, persistence or pace.
 4. Repeated episodes of decompensation, each of extended duration.

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here. Although individual claimants may differ, those with subaverage IQs in the 60–84 range usually receive mental RFCs that are compatible with the ability to perform unskilled work. It is quite possible for the SSA to not consider an IQ over 84 as even requiring an RFC, but rather to decide that the person has mild subaverage intellectual functioning (not severe).

If the claimant has other mental problems of significant severity in addition to a subaverage IQ, these would also have to be addressed on the mental RFC. For example, a particular claimant with an IQ of 65 might have a moderate difficulty in maintaining social functioning, as well as moderate restrictions in activities of daily living. Since these fall

short of the “marked” severity required by parts ① and ② of the listing, they would have to be considered on the mental RFC. But the SSA can suggest lots of unskilled jobs that don't require good social skills.

8. Listing 112.05: Mental Retardation (Children)

See the comments under adult Listing 12.05 regarding mental retardation and regarding learning disorders and communication disorders.

Between ages one and three, developmental tests are useful in children. For example, the Bayley Scales of Infant Development is frequently used by the SSA to obtain a developmental quotient (DQ), which is the developmental age rather than the actual age of the child. Such developmental testing is particularly useful in parts ⑤ and ⑥ of this listing. Other standardized developmental tests are also acceptable.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, it must be characterized by significantly subaverage general intellectual functioning with deficits in adaptive functioning. The required level of severity for this disorder is met when parts ①, ②, ③, ④, ⑤ or ⑥ are satisfied.

- ① For older infants and toddlers (ages one and two), resulting in at least one of the appropriate age-group criteria in part ① of Listing 112.02, for children (ages three through seventeen), resulting in at least two of the appropriate age-group criteria in part ② of 112.02.
- ② Mental incapacity evidenced by dependence upon others for personal needs (grossly in excess of age-appropriate dependence) and inability to follow directions such that the use of standardized measures of intellectual functioning is precluded.
- ③ A valid verbal, performance or full-scale IQ of 59 or less.
- ④ A valid verbal, performance or full-scale IQ of 60 through 70 and a physical or other mental impairment imposing an additional and significant limitation of function.
- ⑤ A valid verbal, performance or full-scale IQ of 60 through 70 and either 1 or 2, below.
 1. For older infants and toddlers (ages one and two), resulting in attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in either parts ⑤1.a or ⑤1.c of Listing 112.02.
 2. For children (ages three through seventeen), resulting in at least one of parts ⑤2.b or ⑤2.c or ⑤2.d of listing 112.02.
- ⑥ Select the appropriate age group:

1. For older infants and toddlers (ages one and two), their condition must result in attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in part ③1.b of Listing 112.02 and a physical or other mental impairment imposing an additional and significant limitation of function. The additional physical or other mental impairment need only be more than mild or slight (more than not severe).
2. For children (ages three through seventeen), their condition must result in the satisfaction of Listing 112.02 ③2.a and a physical or other mental impairment imposing additional and significant limitation of function.

9. Listing 12.06: Anxiety-Related Disorders (Adults)

Anxiety is an uncomfortable emotional state with effects both on the mind and body resulting from anticipation of real or imagined danger. In free-floating anxiety, the person is not aware of the object of danger. Many claimants allege anxiety by stating they are disabled because of nerves. It is important to understand that anxiety is a part of many mental disorders, but this listing concerns specific disorders in which anxiety is the major abnormality. Most claimants alleging nerves have a mild generalized anxiety disorder (see below) or even the normal anxieties of someone without work or sufficient income, and therefore do not qualify under this listing.

a. Listing Level Severity

In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive-compulsive disorders.

The required level of severity is met when both ① and ② are satisfied or both ① and ③ are satisfied. Part ① concerns establishing the type of anxiety-related disorder. Parts ② and ③ establish functional severity.

① Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:
 - a. Motor tension (such as restlessness, trembling or inability to sit still).
 - b. Autonomic hyperactivity (such as increased heart and respiration rates, sweating, weakness and a dry mouth).

- c. Apprehensive expectation (thinking with emphasis on negative consequences and excessive worry).
 - d. Vigilance and scanning (excessive alertness to the environment—that is, fear-based attention is far out of proportion to any danger actually present).
2. A persistent irrational fear of a specific object, activity or situation which results in a compelling desire to avoid the dreaded object, activity or situation. These are irrational fears called phobias. Phobias can exist to any object or situation. For example, a frequent phobia seen by the SSA is agoraphobia, in which there is fear of being away from home or in some public place. If there is simple phobia in which the claimant can avoid the dreaded object, such as fear of high places, the resulting restrictions on their ability to function would be minimal. A social phobia, on the other hand, could be highly restrictive in a person with a job in public relations.
3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week. This describes panic disorder, which is characterized by unpredictable panic attacks with intense anxiety. About 3–4% of people have a panic attack at some time in their lives which then resolves. The prevalence of anxiety attacks is also significant: At any one point in time as many as 11% of the general population may be affected with panic attacks, according to some studies. One such attack would not qualify as a panic disorder. Panic attacks are believed to be caused by biochemical changes in the brain and are treated with certain types of antidepressant medications.
4. Recurrent obsessions or compulsions, which are a source of marked distress. This refers to obsessive-compulsive disorder (OCD). Obsessions are involuntary repetitious thoughts; they can be about anything, but typically involve subjects like aggression, fear of contamination, religion, sex, physical illness or a need to be overly exact. Obsessions cause anxiety that results in compulsive behaviors for relief. A compulsion is an irrationally repeated act or ritual that helps a person decrease anxiety. The exact cause of OCD is not known, but definitely involves the frontal lobes and their interaction with some other brain areas. Treatment with drugs and behavioral conditioning is tried first. Brain surgery has been done in extreme cases, in an attempt to interrupt activity in the abnormal brain circuit. Individual responsiveness to treatment with drugs or behavioral therapy varies.

Patients with OCD generally have a 30–60% reduction in symptoms with medication. Onset of the disorder is usually in the late 20s to early 30s and there is a familial predisposition. Stopping medication causes a high relapse rate of nearly 90%. No cure is available.

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress. This describes post-traumatic stress disorder (PTSD). The original traumatic event can be experienced or witnessed, but must involve the threat of death or serious injury to the person or to others who were present at the time. Additionally, the person's response to this event must have been at the time a sense of overwhelming fear, horror or helplessness. In PTSD, the very painful catastrophic experience forces itself repeatedly back into consciousness, including dreams or reliving the experience, and produces marked emotional distress. These episodes often relate to wartime experiences, but could be any severely disturbing event such as rape or a natural catastrophe or an earthquake or flood that destroys one's family.

Ⓓ The condition results in at least two of the following:

1. Marked restriction of activities of daily living.
2. Marked difficulties in maintaining social functioning.
3. Marked difficulties in maintaining concentration, persistence or pace.
4. Repeated episodes of decompensation, each of extended duration.

Ⓔ The condition results in complete inability to function independently outside the area of one's home.

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here. Additionally, it should be pointed out that significant anxiety would limit the claimant's ability to work in highly stressful situations. Restrictions need to be individualized, depending on the type of anxiety disorder present. For example, a particular claimant may only have a phobia of a specific situation, such as high places or working under water. Other claimants have more severe fears and anxieties that have broader effects on their ability to function and require more restrictions on RFC. Obsessive-compulsive disorder, for example, is one in which the effects would be felt in both personal and work environments.

10. Listing 112.06: Anxiety Disorders (Children)

See the comments under adult Listing 12.06. Part Ⓐ1 deals with separation anxiety and part Ⓐ2 with abnormal fear of

strangers. Parts Ⓐ3–Ⓐ7 match parts Ⓐ1–Ⓐ5 of the adult listing.

a. Listing Level Severity

In these disorders, anxiety is either the predominant disturbance or is experienced if the child attempts to master symptoms—that is, confronts the dreaded object or situation (in a phobic disorder), attempts to go to school (in a separation anxiety disorder), resists the obsessions or compulsions (in an obsessive-compulsive disorder) or confronts strangers or peers (in an avoidant disorder).

The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented findings of at least one of the following:

1. Excessive anxiety when the child is separated, or threatened with separation from a parent or parent surrogate.
2. Excessive and persistent avoidance of strangers.
3. Persistent unrealistic or excessive anxiety and worry (apprehensive expectation), accompanied by motor tension, autonomic hyperactivity or vigilance and scanning.
4. A persistent irrational fear of a specific object, activity or situation which results in a compelling desire to avoid the dreaded object, activity or situation.
5. Recurrent severe panic attacks, manifested by a sudden unpredictable onset of intense apprehension, fear or terror, often with a sense of impending doom, occurring on the average of at least once a week.
6. Recurrent obsessions or compulsions, which are a source of marked distress.
7. Recurrent and intrusive recollections of a traumatic experience, including dreams, which are a source of marked distress.

Ⓑ For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02. For children (ages three through seventeen), the condition results in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

11. Listing 12.07: Somatoform Disorders (Adults)

Somatoform disorders are mental disorders in which physical symptoms are of psychological origin. Somatoform disorders should not be confused with factitious disorders. Factitious disorders are those in which a person intentionally fakes symptoms, with no other aim than assuming the role of a patient. Factitious disorders should also be distinguished

from malingering, in which there is intentional faking of symptoms to obtain some other goal than being a patient, such as avoiding work or obtaining disability benefits.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms. The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms over several years, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly. This describes somatization disorder, characterized by frequent complaints and seeking frequent medical attention for minor physical symptoms.
2. Persistent nonorganic disturbance of one of the following:
 - a. Vision.
 - b. Speech.
 - c. Hearing.
 - d. Use of a limb.
 - e. Movement and its control (such as coordination disturbance, psychogenic seizures, akinesia, dyskinesia).
 - f. Sensation (such as diminished or heightened sensation).

This listing describes conversion disorder, in which psychological factors are responsible for apparent physical abnormalities. People with conversion disorder are emotionally indifferent to their supposed physical abnormalities.

3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury. This describes hypochondriasis, in which preoccupation with symptoms erroneously thought to represent severe physical disease persist despite medical evaluation and assurance that none is present.

Ⓑ Resulting in three of the following:

1. Marked restriction of activities of daily living.
2. Marked difficulties in maintaining social functioning.
3. Marked difficulties in maintaining concentration, persistence or pace.
4. Repeated episodes of decompensation, each of extended duration.

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here.

12. Listing 112.07: Somatoform, Eating and Tic Disorders (Children)

See the comments under adult Listing 12.07. Here, parts Ⓐ3 and Ⓐ4 match parts Ⓐ2 and Ⓐ3 in the adult Listing, with an additional section for digestive symptoms or symptoms of waste elimination such as chronic constipation.

Eating disorders such as anorexia nervosa and bulimia require the use of weight tables found in a specific medical book—which must be the most recent edition. Doctors caring for children would probably have this book, as would medical school libraries and some large bookstores.

Anorexia nervosa is a serious mental disorder, usually found in females, and characterized by the fear of excessive weight gain although the person is markedly underweight. By definition, anorexia nervosa requires a weight less than 85% of the person's expected normal weight. People with anorexia do not recognize the seriousness of their disorder or the very disturbed way they perceive their bodies, and the mortality rate is high. Subtypes of anorexia nervosa involve people whose eating patterns don't include binge eating (restricting type) as well as those who engage in binge eating or purging with laxatives, vomiting or enemas (binge-eating/purging type). The binge-eating/purging type actually has episodes of bulimia as a part of their anorexia nervosa.

Bulimia is a mental eating disorder, usually in younger females, characterized by episodes of binge eating. Bulimics may engage in self-induced vomiting after eating, laxatives or enemas in an attempt to keep from gaining weight (purging type) or try to lose weight by excessive exercise or fasting (nonpurging type). Bulimia nervosa is the medical name for bulimia. The diagnosis of bulimia does not apply to individuals who have bulimic episodes as a part of anorexia nervosa. Anorexia nervosa is a much more serious disorder, but people with bulimia could die from a ruptured esophagus, ruptured stomach, aspiration pneumonia from regurgitating food into their lungs or taking inappropriate drugs to treat their overeating.

A tic is an involuntary, repetitive, rapid, purposeless movement. Tics are most often seen in the facial muscles, but may also involve muscles in other locations. Tics can be of physical cause, such as in Tourette's syndrome, or of psychological cause. This listing uses language suggesting Tourette's syndrome, a rare physical disorder of unknown cause. The vocal tics produced involuntarily may be obscene sounds or words, snorting or barking noises. Tourette's

often responds to medication. In other cases, there may be secondary emotional disorders related to social difficulties caused by obscene and involuntary vocal tics. The disorder may improve after some years, but is incurable.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, the child must have a somatoform disorder manifested by physical symptoms for which there are no demonstrable organic findings or known physiologic mechanisms or an eating or tic disorder with physical manifestations. The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Medically documented findings of one of the following:

1. An unrealistic fear and perception of fatness despite being underweight, and persistent refusal to maintain a body weight which is greater than 85% of the average weight for height and age, as shown in the most recent edition of the *Nelson Textbook of Pediatrics*, Behrman and Vaughan, editors (W.B. Saunders Company).
2. Persistent and recurrent involuntary, repetitive, rapid, purposeless motor movements affecting multiple muscle groups with multiple vocal tics.
3. Persistent nonorganic disturbance of one of the following:
 - a. Vision.
 - b. Speech.
 - c. Hearing.
 - d. Use of a limb.
 - e. Movement and its control—coordination disturbance, psychogenic seizures.
 - f. Sensation—diminished or heightened.
 - g. Digestion or elimination.
4. Preoccupation with a belief that one has a serious disease or injury.

Ⓑ For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part Ⓑ1 of Listing 112.02. For children (age three through seventeen), the condition results in at least two of the appropriate age-group criteria in part Ⓑ2 of 112.02.

13. Listing 12.08: Personality Disorders (Adults)

Various personality disorders include paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, obsessive-compulsive and personality disorder not otherwise specified. Different personality disorders may share some of the same features, so that it is

not possible to assign the numbers in part Ⓐ to a specific disorder. For example, a paranoid personality disorder would be expected to have the features of pathologically inappropriate suspiciousness or hostility, but this could also be present in schizotypal personality disorder.

Delusions and odd beliefs are most likely with schizoid, schizotypal and avoidant personality disorders, as is avoidance of normal social interactions and odd or magical thinking. These individuals are particularly likely to be socially withdrawn and socially incapacitated.

Persistent disturbances of mood or affect are applicable to narcissistic and histrionic personality disorders, but may be relevant to many other personality disorders. Individuals with narcissistic personality disorder are preoccupied with self-importance and self-admiration, while histrionic personalities are emotionally over-reactive, emotionally shallow and overly suggestible.

Pathological dependence, passivity or aggressivity is especially relevant to those with dependent personality disorder. Intense and unstable interpersonal relationships and impulsive and damaging behavior can be found in those with borderline personality disorder, a mental illness that is sometimes disabling. This would also apply to claimants with antisocial personality disorders, but they would almost never qualify under the listing. People with antisocial personality disorders used to be called sociopaths and before that they were referred to as psychopaths.

Generally, claimants with personality disorders are far less likely to qualify for disability than those with the much more serious psychotic or affective (mood) disorders seen by the SSA. Most are capable of some type of work consistent with their particular mental limitations. Note that obsessive-compulsive personality disorder evaluated under this listing is not the same as obsessive-compulsive disorder (OCD) evaluated under Listing 12.04. OCD is much more severe and much more likely to be disabling.

a. Listing Level Severity

A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness. The required level of severity is met when both Ⓐ and Ⓑ are satisfied. Part Ⓐ concerns establishing the type of disorder. Part Ⓑ establishes functional severity.

Ⓐ Deeply ingrained, maladaptive patterns of behavior associated with one of the following:

1. Seclusiveness or autistic thinking.
2. Pathologically inappropriate suspiciousness or hostility.

3. Oddities of thought, perception, speech and behavior.
4. Persistent disturbances of mood or affect.
5. Pathological dependence, passivity or aggressivity.
6. Intense and unstable interpersonal relationships and impulsive and damaging behavior.

Ⓑ The condition results in three of the following:

1. Marked restriction of activities of daily living.
2. Marked difficulties in maintaining social functioning.
3. Marked difficulties in maintaining concentration, persistence or pace.
4. Repeated episodes of decompensation, each of extended duration.

b. Residual Functional Capacity

The comments about RFC under Listing 12.02 also apply here. Because of the numbers of types of personality disorders, the RFC must be highly individualized. For example, paranoid thinking will limit working closely with others, while a person with dependent personality might require close supervision. Despite the variety of restrictions that might be involved in individual cases, almost all cases of personality disorder are capable of at least unskilled work, and their claims will usually be denied by the SSA on a medical-vocational basis.

14. Listing 112.08: Personality Disorders (Children)

See the comments under adult Listing 12.08. Part Ⓐ of this listing is the same as 12.08, except for an additional part Ⓐ7, mentioning perfectionism and inflexibility, which are abnormalities associated with obsessive-compulsive personality disorder.

a. Listing Level Severity

Personality disorders in children that meet the listing are manifested by pervasive, inflexible and maladaptive personality traits, which are typical of the child's long-term functioning and not limited to discrete episodes of illness. The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

Ⓐ Deeply ingrained, maladaptive patterns of behavior, associated with one of the following:

1. Seclusiveness or autistic thinking.
2. Pathologically inappropriate suspiciousness or hostility.
3. Oddities of thought, perception, speech and behavior.
4. Persistent disturbances of mood or affect.
5. Pathological dependence, passivity or aggressiveness.

6. Intense and unstable interpersonal relationships and impulsive and exploitative behavior.
7. Pathological perfectionism and inflexibility.

Ⓑ For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part Ⓐ1 of Listing 112.02. For children (ages three through seventeen), the condition results in at least two of the appropriate age-group criteria in part Ⓐ2 of 112.02.

15. Listing 12.09: Substance Addiction Disorders (Adults)

Substance addiction disorders are evaluated under whatever listings are most appropriate to the complications produced by the abuse of drugs. Alcohol abuse is a frequent cause of complications. Chronic cocaine use can cause significant mental abnormalities (such as personality changes and paranoia).

Federal law prohibits payment of SSDI or SSI benefits and Medicare or Medicaid coverage based on those benefits to people who are disabled because of drug addiction and/or alcoholism (DAA) to the extent that their problems would be reversible by ceasing the addictive activity. In other words, you can be disabled because of irreversible organ damage caused by DAA. See Chapter 11 regarding how the SSA evaluates DAA.

Many claimants with DAA have other mental disorders, and questions arise concerning the relative contributions of drugs and alcohol versus the other mental disorder. For example, how does one evaluate a claimant with chronic schizophrenia who also abuses cocaine? Which symptoms are due to drug use and which are related to schizophrenia? How do the drugs increase the severity of the schizophrenic symptoms? How much improvement in the schizophrenia would one see if the drug abuse ended? These cases require expert judgment and are susceptible to error. If possible, records from a time the claimant was free of alcohol or drugs would be very helpful. To the extent that the SSA lacks reasonable certainty as to the contribution of DAA to a mental or physical disorder, the benefit of the doubt would generally go to the claimant.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system. The required level of severity is met when any of the following parts (Ⓐ through ①) are satisfied.

- Ⓐ Organic mental disorders. Evaluate under Listing 12.02.
- Ⓑ Depressive syndrome. Evaluate under Listing 12.04.

- Ⓒ Anxiety disorders. Evaluate under Listing 12.06.
- Ⓓ Personality disorders. Evaluate under Listing 12.08.
- Ⓔ Peripheral neuropathies. Evaluate under Listing 11.14 (Chapter 26).
- Ⓕ Liver damage. Evaluate under Listing 5.05 (Chapter 20).
- Ⓖ Gastritis. Evaluate under Listing 5.04 (Chapter 20).
- Ⓗ Pancreatitis. Evaluate under Listing 5.08 (Chapter 20).
- Ⓘ Seizures. Evaluate under Listing 11.02 or Listing 11.03 (Chapter 26).

b. Residual Functional Capacity

Residual functional capacity must be determined on an individual basis, depending on the types of abnormalities and functional limitations present. See the discussion of RFC under the particular listing used to evaluate the claim.

16. Listing 112.09: Psychoactive Substance Dependence Disorders (Children)

See Chapter 11 regarding prohibition of disability payments for drug addiction and/or alcoholism (DAA). Because this listing is for substance addiction alone—the very thing federal law prohibits as being the basis for disability—it cannot be used to find a child disabled. Instead, the SSA would decide if the child's substance dependence is severe enough to satisfy the listing. If not, the claim would be denied. If the impairment is severe enough to meet the listing, the SSA would then decide that the DAA was material to the finding of disability and would deny it anyway because the child can't be allowed benefits for substance dependence. This is bureaucracy at its finest. However, to the extent that a child has a mental or physical disorder that would remain after cessation of DAA (even if the DAA originally caused the problem), they could still be found disabled under the appropriate other listing, but not this one.

a. Listing Level Severity

For the child's condition to be severe enough to meet the listing, it must be manifested by a cluster of cognitive, behavioral and physiologic symptoms that indicate impaired control of psychoactive substance use, along with continued use of the substance despite adverse consequences. Part Ⓐ is for diagnostic purposes; part Ⓑ is for evaluation of functional severity. The required level of severity is met when both Ⓐ and Ⓑ are satisfied.

- Ⓐ Medically documented findings of at least four of the following:
 1. Substance taken in larger amounts or over a longer period than intended with a great deal of time spent in recovering from its effects.

2. Two or more unsuccessful efforts to cut down or control use.
3. Frequent intoxication or withdrawal symptoms interfering with major role obligations.
4. Continued use despite persistent or recurring social, psychological or physical problems.
5. Tolerance, as characterized by the requirement for markedly increased amounts of substance in order to achieve intoxication.
6. Substance taken to relieve or avoid withdrawal symptoms.

- Ⓑ For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part Ⓐ1 of Listing 112.02. For children (ages three through seventeen), the condition results in at least two of the appropriate age-group criteria in part Ⓐ2 of 112.02.

17. Listing 12.10: Autistic Disorder and Other Pervasive Developmental Disorders (Adults)

Autism (autistic disorder) is a form of pervasive developmental disorder, for which there are a number of specific diagnostic criteria. Although this listing concerns autism in adults, the diagnosis is based on childhood developmental abnormalities, as you'll see mentioned below. Basically, autism may be associated with:

- *Severe deficits in social interaction*—lack of nonverbal behaviors usually present in social interactions, such as gestures, body postures and facial expressions; failure to develop social relationships with other children the same age (peers); lack of spontaneous sharing of enjoyment or interests with other people; lack of sharing emotions with others (lack of emotional or social reciprocity).
- *Severe impairments in communication*—delay or lack of development of spoken language with no attempt to compensate by other means of communication. For example, a normal deaf child will attempt to learn and communicate with sign language, but an autistic child will not. Other communication abnormalities may involve inability to start or keep up a conversation with others even if speech ability is present; repetitive use of language or personalized (idiosyncratic) language; lack of socially imitative play or make-believe play that would normally be appropriate to the child's level of development.
- *The persistent repetition of senseless acts or interests (stereotyped behavior)*—preoccupation with restricted interests; insistence on sticking to certain unnecessary routines or rituals; stereotyped mannerisms; and an

abnormal interest (preoccupation) with the parts of objects.

- *Abnormal functioning before age three years*—abnormal functioning or delayed development in the following:
 1. social interaction
 2. language as used in social communication, or
 3. play involving imagination or symbolism.

Not all of the above abnormalities of autism need to be present for a diagnosis of the disorder. Part ① of the listing concerns establishing the diagnosis of a pervasive developmental disorder. “Qualitative deficits” mentioned in part ① refers to an identifiable problem being present, and not level of functional severity, which is evaluated under part ②.

Autism is an extremely severe mental disorder with a poor prognosis. Part ①1 is specifically for autism. If a claimant actually has autism, it is virtually certain they will be given an allowance under this listing. Denial of a claimant with autism should cause the question to be raised that either the determination of denial is wrong or that the diagnosis of autism is wrong. For example, it would be unusual for someone with autism to not have marked limitations in daily activities (part ①1) or social functioning (part ②2).

Developmental disorders other than autism are also considered under part ①2 of the listing, but are much less likely to be allowances than autistic disorder.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must be characterized by qualitative deficits in your development of reciprocal social interaction, in the development of verbal and nonverbal communication skills and in imaginative activity. Often, there is a markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

The required level of severity for these disorders is met when the requirements in both parts ① and ② are satisfied.

① Medically documented findings of the following:

1. For autistic disorder, all of the following:
 - a. Qualitative deficits in the development of reciprocal social interaction.
 - b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity.
 - c. Markedly restricted repertoire of activities and interests.
2. For other pervasive developmental disorders, both of the following:
 - a. Qualitative deficits in the development of reciprocal social interaction.

b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity.

② The disorder results in at least two of the following:

1. Marked restriction of activities of daily living.
2. Marked difficulties in maintaining social functioning.
3. Marked difficulties in maintaining concentration, persistence or pace.
4. Repeated episodes of decompensation, each of extended duration.

18. Listing 112.10: Autistic Disorder and Other Pervasive Developmental Disorders (Children)

Autism (autistic disorder) is not mental retardation. Autism is a form of pervasive developmental disorder, for which there are a number of specific diagnostic criteria. Basically, autism may be associated with:

- *Severe deficits in social interaction.* Examples include a lack of nonverbal behaviors usually present in social interactions, such as gestures, body postures and facial expressions; failure to develop social relationships with other children the same age (peers); lack of spontaneous sharing of enjoyment or interests with other people; and lack of sharing emotions with others (lack of emotional or social reciprocity).
- *Severe impairments in communication.* Delay or lack of development of spoken language with no attempt to compensate by other means of communication. For example, a normal deaf child will attempt to learn and communicate with sign language, but an autistic child will not. Other communication abnormalities may involve inability to start or keep up a conversation with others even if speech ability is present; repetitive use of language or personalized (idiosyncratic) language; lack of socially imitative play or make-believe play that would normally be appropriate to the child's level of development.
- *The persistent repetition of senseless acts or interests (stereotyped behavior).* Examples include preoccupation with restricted interests; insistence on sticking to certain unnecessary routines or rituals; stereotyped mannerisms; and an abnormal interest (preoccupation) with the parts of objects.
- *Abnormal functioning before age three.* Abnormal functioning or delayed development in the following: (1) social interaction, (2) language as used in social communication or (3) play involving imagination or symbolism.

Not all of the above abnormalities of autism need to be present for a diagnosis of the disorder. Qualitative deficits refer to an identifiable problem being present and not level of functional severity, which is evaluated under part ②.

Autism is an extremely severe mental disorder with a poor prognosis. If a claimant actually has autism, it is virtually certain he will be found disabled under this listing. Denial of a claimant with autism should mean that either the determination of denial is wrong or that the diagnosis of autism is wrong. Developmental disorders other than autism are also considered here, but are much less likely to be allowances than autistic disorder. Children less than one year old who have developmental disorders are evaluated under Listing 112.12.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, it must be characterized by qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills and in imaginative activity. Often, there is a markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive. The required level of severity is met when both ① and ② are satisfied.

① Medically documented findings of 1 or 2:

1. For autistic disorder, all of the following:
 - a. Qualitative deficits in the development of reciprocal social interaction.
 - b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity.
 - c. Markedly restricted repertoire of activities and interests.
2. For other pervasive developmental disorders, both of the following:
 - a. Qualitative deficits in the development of reciprocal social interaction.
 - b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity.

② For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part ① of Listing 112.02. For children (ages three through seventeen), the condition results in at least two of the appropriate age-group criteria in part ② of 112.02.

19. Listing 112.11: Attention Deficit Hyperactivity Disorder (Children)

Attention deficit hyperactivity disorder (ADHD) is a common childhood disorder. It is characterized by impulsive behavior,

difficulty maintaining attention and hyperactivity. Of course, these characteristics are to some extent natural in a young child and should not be confused with ADHD. ADHD children will not sit still very long and are into everything. If of school age, they typically have difficulty completing their lessons because they can't maintain their attention long enough. Consequently, their grades suffer. They impulsively respond to every little distraction.

The cause of ADHD is unknown, but there is evidence of abnormal brain function. Mental retardation is not an expected part of ADHD and it is controversial whether IQs in these children are lower than normal children matched for other similarities (age, socioeconomic condition and the like). IQ scores obtained from hyperactive, inattentive children are not valid, if the child displays these abnormalities during the test enough to affect the results. If IQ or other testing is done, the psychologist administering the test must be skilled in maintaining the child's attention and effort.

Treatment of ADHD usually consists of behavior therapy (which must also involve the parents) and drugs. Various drugs used include certain kinds of antidepressants, dextro-amphetamine and methylphenidate (Ritalin). The side effects of drugs should be taken into account during disability determination. It is important to the nondrug part of treatment that the child's environment be highly organized (structured) both at home and at school if possible. Treatments like restriction of sugar, dosing with megavitamins or dietary restrictions are not effective.

If a child has all three of the mental status abnormalities of marked inattention, marked impulsiveness and marked hyperactivity, in addition to certain functional restrictions, then allowance level severity is present. Most children with ADHD are not disabled—the listing applies only to the most severe cases of ADHD.

a. Listing Level Severity

Part ① of the listing is used to establish the presence of the attention deficit hyperactivity disorder (ADHD). Part ② of the listing is used to establish functional severity. The required level of severity is met when both ① and ② are satisfied.

① Medically documented findings of all three of the following:

1. Marked inattention.
2. Marked impulsiveness.
3. Marked hyperactivity.

② For older infants and toddlers (ages one and two), the condition results in at least one of the appropriate age-group criteria in part ① of Listing 112.02. For children (ages three through seventeen), the condition results in

at least two of the appropriate age-group criteria in part ② of 112.02.

20. Listing 112.12: Developmental and Emotional Disorders of Newborns and Younger Infants (Birth to Attainment of Age 1) (Children)

Any type of physical or mental medical disorder can be used to satisfy this listing in children under age one year. Potential causes of marked developmental or emotional disorders include malformations of the brain at birth, infections of the brain, strokes, genetic disorders of brain metabolism or any other disorder affecting the brain function. Autism and other pervasive developmental disorders in children under age one year are also evaluated under this listing. See comments under child Listing 112.10 for more information about autism.

A child's developmental level is measured with tests designed for that purpose, such as the Bayley Scales of Infant Development that yields a developmental quotient (DQ). Not all parts of the listing require formal testing, but it may be necessary to obtain accurate results in unclear cases—of which there are many. In cases of obvious marked severity based on clinical observations by a doctor and supported by parental and other information, formal testing is not required. The need for specific formal testing is a matter of medical judgment in each individual claim.

a. Listing Level Severity

Developmental or emotional disorders of infancy are evidenced by a deficit or lag in the areas of motor, cognitive/communicative or social functioning. These disorders may be related either to organic or to functional factors or to a combination of these factors. The required level of severity is met when ①, ②, ③, ④ or ⑤ are satisfied.

- ① Cognitive/communicative functioning generally acquired by children no more than one-half the child's chronological age, as documented by appropriate medical findings (in infants under six months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking, swallowing or chewing) including, if necessary, a standardized test.
- ② Motor development generally acquired by children no more than one-half the child's chronological age, documented by appropriate medical findings, including if necessary, a standardized test.
- ③ Apathy, overexcitability or fearfulness, demonstrated by an absent or grossly excessive response to one of the following:
 1. Visual stimulation.
 2. Hearing stimulation.
 3. Touch stimulation.
- ④ Failure to sustain social interaction on an ongoing, reciprocal basis as evidenced by:
 1. Inability by six months to participate in vocal, visual and movement (motoric) social exchanges (including facial expressions).
 2. Failure by nine months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger.
 3. Failure to attend to the caregiver's voice or face or to explore an inanimate object for a period of time appropriate to the infant's age.
- ⑤ Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas (i.e., cognitive/communicative, motor and social), documented by appropriate medical findings, including, if necessary, standardized testing. ■

Chapter 28

Cancer

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Angiography. Any technique to produce images of arteries, such as by x-rays or MRI scans. Usually involves injection of contrast material into the artery to make it visible. Also known as *arteriography*.

Angiosarcoma. A cancerous connective tissue tumor that could be either of blood vessels (hemangiosarcoma) or lymphatic vessels (lymphangiosarcoma).

Antineoplastic drugs. Drugs used to treat cancer.

Ascites. Abnormal accumulation of fluid in the abdomen. A frequent cause of ascites is liver failure associated with alcoholism. However, cancer can also be a cause, especially cancer of the ovaries.

Astrocytoma. Malignant brain tumors arising from the astrocyte cells of the brain. May be of varying degrees of malignancy.

Axilla. Armpit.

Benign. Noncancerous.

Biopsy. The process of taking a sample of tissue for detailed analysis of various kinds. Biopsy specimens are observed grossly with the eyes, microscopically with a variety of possible tissue stains and, in some cases, may involve specific chemical and DNA analysis.

Bowel. Intestine.

Bronchoscopy. Direct visualization of the bronchial tubes that carry air to and from the lungs. Used to take tissue samples (biopsy) of abnormalities, such as tumor and infections, for diagnostic purposes.

Cancer. A multiplication of abnormal cells, the natural course of which is fatal if untreated. The two important characteristics of cancer are that, unlike normal tissues, cancerous cells may be invasive to surrounding structures and may also spread to other locations in the body (metastasize). Also known as *malignancy*.

Carcinoembryonic antigen (CEA). Substance measured by a blood test as a possible marker for recurrence of various types of cancer, such as for recurrence of lung cancer, breast cancer and colon cancer. However, it is not diagnostic for the recurrence of cancer.

Carcinogenic. Anything that promotes the development of cancer.

Carcinomas. Cancers of epithelial tissues, such as the skin, mucous membranes in the mouth and nose, cells lining the bronchi of the lungs and glandular tissue in the breasts or lining the inside of the large intestine. When glandular tissue is involved, the cancer is some type of adenocarcinoma. Colon cancer is often an adenocarcinoma.

Chemotherapy. Treatment of a medical disorder with drugs. Adjuvant chemotherapy is drug treatment given just after a local treatment, such as surgical removal of a tumor. Primary chemotherapy means drugs are given before a local treatment or instead of a local treatment.

Colectomy. Removal of a part of the colon. A total colectomy means removal of the entire colon.

Colon. The large intestine.

Colostomy. Surgically placed opening from the colon through the abdominal wall to the outside of the body.

Computerized axial tomography (CAT Scan, CT Scan) of abdomen. Multiple x-ray "slices" of abdominal structures that are analyzed by a computer and made into detailed images.

Cryotherapy. Treatment by application of cold, such as freezing a tumor.

Cystectomy. Removal of the bladder.

Epidermoid carcinoma. See *squamous cell carcinoma*.

Erythema. Redness of the skin caused by increased blood flow in the small capillary blood vessels. Erythema often accompanies inflammation, because inflammation is associated with the release of substances that dilate blood vessels and increase blood flow.

Excision. See *resection*.

Extension (of tumor). Invasion of nearby tissues by direct tumor growth; should not be confused with metastasis.

Fibroma. Any benign tumor of fibrous connective tissue.

Fibrosarcoma. A cancerous tumor of fibrous connective tissue.

Frozen section. A thin slice of frozen tissue given by a surgeon to a pathologist for microscopic examination during surgery. If cancer is present, the frozen section diagnosis permits the surgical procedure to be adjusted accordingly, such as widening the area of tissue to be removed.

Hemangioma. A benign tumor made up of blood vessels.

Hemangiosarcoma. A rare and highly malignant connective tissue tumor of blood vessels.

Hilar lymph nodes. Nodes situated in the hilum of each lung, a location where arteries, veins and lymphatic vessels enter the right or left lung.

Hormone-dependent tumors. Tumors that are stimulated in their growth by certain hormones. For example, prostate cancer is stimulated by the male sex hormone testosterone and some breast cancers have receptors for the female sex hormones estrogen and progesterone. These female sex hormones stimulate the cancers that have receptors for them.

Hysterectomy. Removal of the uterus.

Induration. Abnormal hardening of tissue.

In situ. The earliest stage of a cancer, in which it is still confined to its cell layer of origin.

Laryngectomy. Removal of the larynx.

Larynx. Structure of hard cartilage that holds the vocal cords; voice box.

Definitions (continued)

Leiomyoma. A benign tumor of smooth muscle. Smooth muscle is muscle not under voluntary control, such as in the intestines and the uterus, which are the locations in which most leiomyomas are found. Leiomyomas of the uterus are popularly known as uterine fibroids.

Leiomyosarcoma. A malignant tumor of smooth (involuntary) muscle, such as cancers arising from the muscles of the uterus or intestines.

Leukemia. Any of the of white blood cell cancers arising in the bone marrow or lymph nodes. Specific leukemias are named according to which type of white cell is involved, such as lymphocytic leukemia and myelocytic leukemia. Leukemia is also classified as acute or chronic. Acute leukemias are those with the most cancerous cells, while chronic leukemias have more normal cells.

Lipoma. A common, benign tumor of fatty (adipose) tissue.

Liposarcoma. A cancerous tumor arising from fatty tissue.

Lobectomy. Removal of a lobe of a lung.

Low-grade malignancy. Reference to relatively slowly growing and less aggressive cancer.

Lymphangiography. X-rays of the lymphatic system following the injection of x-ray contrast material.

Lymphangioma. A benign tumor made up of lymphatic vessels that can occur almost anywhere in the body.

Lymphangiosarcoma. A highly cancerous and rare connective tissue tumor of lymphatic vessels.

Lymph nodes. Specialized collections of cells found in various locations along the system of lymph vessels. Lymph nodes function for the immune system and contain lymphocytes. For example, lymph nodes can trap and destroy bacteria. Lymph nodes also may contain cancerous cells that are being spread through the lymphatic system. Therefore, biopsy of lymph nodes is important in determining whether cancer has metastasized from the original tumor.

Lymphomas. Cancers of the lymph nodes and spleen that result in abnormal lymphocytes. Lymphoma can invade any organ of the body. Hodgkin's and non-Hodgkin's lymphoma are two important classifications.

Lymphoproliferative disorders. See *lymphomas*.

Lymphoscintigraphy. Method of visualizing lymph nodes by injection of a radioactive substance and making images of lymph nodes that concentrate the radioactivity. Lymphoscintigraphy is used for detecting spread of cancer to lymph nodes.

Magnetic resonance imaging (MRI). Method of producing pictures of internal body structures using magnetic fields and radiofrequency fields. MRIs do not utilize x-rays or other radiation.

Malignant. Cancerous.

Mandible. Lower jaw bone.

Maxilla. Upper jaw bone.

Mean survival. The mean survival regarding cancer is the average survival time.

Median survival. In regard to cancer or other disease, that amount of time in which half the patients live longer and half the patients live shorter times. It is a statistical method of description, at which the survival probability curve is divided in half.

Mediastinum. The space between the two lungs containing the heart, bronchi, esophagus, trachea, lymph nodes and other structures.

Malignant melanoma. A highly cancerous and dangerous skin tumor that can spread through the body. Once spread to other organs occurs, the prognosis is grave. The risk of melanoma increases with exposure to sunlight.

Meninges. Membranes covering the brain and spinal cord. The thickest, outer meningeal membrane is called the dura mater, which surgical or other medical reports usually just call the "dura."

Mesothelioma. A type of sarcoma arising from cells in the pericardium, the membrane lining the abdominal cavity (peritoneal membrane) or membranes lining the inside of the chest wall and outside of the lungs (pleural membranes). Most mesotheliomas, such as caused by asbestos exposure, are cancerous.

Metastasis. The spread of cancerous cells from their site of origin to other locations in the body. There are two ways in which cancerous cells metastasize: through the blood stream and through the lymphatic vessels. Not all cancers metastasize, and some cancers have a greater likelihood of metastasizing than others. *Distant metastasis* means spread of the cancer far enough beyond the origin of the cancer (primary tumor) that resection cannot be done for cure. Spread of tumor by direct growth is called *extension*, not metastasis.

Note: The listings sometimes say "metastasis" and sometimes use the plural form of the word "metastases." This distinction between the single and multiple metastatic tumors is irrelevant for purposes of the listings. Also, doctors treating patients do not use these words with distinction. If doctors want to emphasize the presence of one metastatic tumor, they will say a *single* metastasis in order to clarify the issue. Similarly, they will usually say *multiple* metastases when they want to emphasize that there is more than one lesion.

Myoma. A muscle tumor, without reference as to whether it is cancerous or benign.

Neoplasm. A tumor that may be either benign or cancerous.

Neurilemoma. A benign tumor arising from nerves. Also known as a *schwannoma*.

Orbit. Eye socket.

Pericardium. Thin membrane that surrounds the heart.

Peritoneum. The membrane lining the walls of the abdomen and pelvis and covering the abdominal organs.

Pleura. The moist membrane that covers the outside of the lungs and the inside of the chest cavity.

Pneumonectomy. Complete removal of a right or left lung.

Definitions (continued)

Poorly differentiated. Reference to cancers that are more malignant—for example, more aggressive in their growth and spread. Differentiation refers to the amount of specialized structure in a cell. Normal cells have a specific structure designed for a specific function—such as bone or brain—while poorly differentiated cancerous cells cannot be identified with any particular type of tissue.

Primary tumor. The first tumor created by a cancer. Other (secondary) tumors may grow from cells that have metastasized from the primary tumor to other locations in the body.

Prostate specific antigen (PSA). Substance measured by a blood test as a possible marker for adenocarcinoma cancer of the prostate gland. Normal levels are 0–4 nanograms/milliliter (ng/ml).

Radiotherapy. Treatment with radiation, such as x-rays or gamma rays.

Rectum. The final section of the large intestine.

Regional lymph nodes. The lymph nodes that are closest to a particular area of the body under consideration and refer to those nodes that first receive lymphatic drainage from a cancerous tumor. Therefore, regional lymph nodes are likely to trap some cancerous cells. If regional nodes are not involved with cancer it is a good prognostic sign that perhaps the cancer has not spread beyond the tumor to more distant places in the body (distant metastasis). If the regional nodes are involved with cancer, the reasonable presumption is that the cancer may have spread beyond them.

Resection. Surgical removal of tissue.

Rhabdomyoma. A benign tumor of skeletal muscle. Skeletal muscle is that under voluntary control, such as in the arms and legs. The muscles of the neck, tongue, face, abdomen and back are also skeletal muscles.

Rhabdomyosarcoma. A malignant tumor of skeletal muscle, such as a cancer originating in a thigh muscle.

Sarcoma. Cancers of connective tissue, such as those involving bone, muscle and cartilage. For example, cancers of

muscle are various types of myosarcoma. Cancers of cartilage are chondrosarcomas. Cancers of bone are osteosarcomas.

Sentinel node. The first lymph node that receives lymphatic drainage from a tumor. If the sentinel node is negative for cancer, it is important prognostic information that the cancer may not have spread to more distant sites from the primary tumor.

Squamous cell carcinoma (SCC). Carcinoma that arises from squamous cells. Squamous cells form the outside of the skin, the lining of the mouth and nasal passages, larynx and the lining of the bronchial airways in the lungs. Also known as *epidermoid carcinoma*.

Staging. A standardized way of describing how much a particular kind of cancer has spread. Staging systems vary between cancer types, but usually involve Stages I, II, III and IV. Stage IV cancers are the most advanced. Sometimes, the letters “A” or “B” are also used, such as Stage IA soft tissue sarcoma.

Systemic. Referring to the body as a whole.

Temporal fossa. The area defined by the temporal bone on the sides of the skull.

TMN classification. A classification system used for staging cancer. T refers to the size of the primary tumor, N refers to the degree of lymph node involvement around the tumor and M refers to the degree of metastasis of the cancer. TMN classification systems vary with the type of cancer involved.

Topical drugs. Drugs applied to the surface of the body, such as the skin.

Tracheostomy. Surgically placed opening through the neck into the trachea. May be temporary or permanent and is used to connect a respirator for mechanical ventilation for patients who need assistance in breathing. Patients who have had a laryngectomy also have a tracheostomy.

Tumor. Abnormal proliferation of cells in one place, forming a mass. Tumors can be either benign or malignant. Also known as a *neoplasm*.

A. General Information

Factors that the SSA uses to determine the level of impairment from cancer include:

- the type of cancer
- the location of the cancer
- the degree that the cancer involves other normal tissues
- the response to therapy, and
- the severity of residual problems after treatment.

Treatment of cancer usually involves surgery, radiation, hormones, chemotherapy or some combination of treatments. There are also treatments using antibodies.

1. Diagnosis

The diagnosis of cancer must be established based on the signs, symptoms and laboratory findings. The site of the primary cancerous tumor must be documented, as well as sites of recurrent cancer and cancer that has spread to other parts of the body to produce secondary tumors (metastatic tumors). If surgery has been done, the SSA requires a copy of the operative note that the surgeon dictates about the procedure, as well as a report on the gross visual and microscopic examination of any surgical specimens removed from the patient. Microscopic examination of tissue specimens by a pathologist is critical to the accurate diagnosis of cancer. If these documents are not obtainable by the SSA, then the summary of hospitalization or a report from the treating doctor must include details of the findings at surgery and the results of the pathologist's gross and microscopic examination of the tissues. However, the SSA much prefers the actual reports of the surgeon and pathologist.

2. Spread of Cancer (Metastasis)

In order to prove the diagnosis of a primary cancerous tumor, whether originating in bone or elsewhere, a biopsy is required. Metastatic tumors are ideally diagnosed with biopsy also. However, the biopsy of metastatic lesions is often not practical for a number of reasons. For example, the patient may be too sick for surgery, or the metastatic lesion may be in a location difficult to reach surgically—such as a deep brain lesion. Imaging studies such as radionuclide scans, magnetic resonance imaging (MRI), computerized axial tomography (CAT) scans and even plain x-rays may provide a reasonable justification to think that an abnormality seen somewhere in the body is a metastatic cancer. In some instances, it is difficult to decide whether a bone lesion is cancer, and medical judgment is required. However, if the

doctor responsible for treating a claimant's cancer thinks that a lesion is a metastatic cancer and treats it accordingly, the SSA should not dispute that judgment in its determination. If a treating doctor tells the SSA that he or she thinks something seen on x-ray or other imaging studies is a metastatic cancer, but doesn't treat it as such, then the statement to the SSA would be treated as suspect in motive.

When a cancerous tumor has apparently been completely removed surgically and has not spread beyond the regional lymph nodes, the SSA usually assumes that further spread or recurrence of cancer is not likely in the near future. However, in some of the listings, the SSA considers some forms of cancer disabling, even though they are not disabling at the time of application for benefits. This conclusion is based on the probability of progression of the cancer, even if there is apparent removal of all of the cancer. In such instances, medical evidence should include a report of a recent examination describing the location and extent of any cancer present, as well as any impairment remaining after treatment.

For disability determination purposes, "distant metastases" or "metastases beyond the regional lymph nodes" refers to spread beyond an area that could be completely removed with the usual radical surgery (called radical en bloc resection) for the cancer involved. It is important to understand that a distant metastatic lesion is sometimes surgically removed, but this does not alter the fact that distant metastasis has occurred and there is a high probability that cancer will appear in other locations. For example, suppose a claimant with lung cancer is found to have a single tumor in the brain that consists of lung tumor cancer cells, which are a distant metastasis of the lung cancer. If the brain metastasis was removed surgically or otherwise treated to disappear, the treatment would not change the fact that the claimant has distant metastasis for purposes of the listings.

When a cancerous tumor has metastasized beyond the regional lymph nodes, the impairment will usually be found to meet the requirements of the listings. However, there are exceptions, such as hormone-dependent tumors, tumors sensitive to radioactive isotopes and metastases from seminoma of the testicles which are controlled by definitive therapy. Such exceptions are noted in the listings concerned.

3. Recurrence or Incomplete Removal of Cancer

Recurrence of cancer near the site of a previous radical surgical removal of a tumor or evidence of incomplete surgical removal of cancer, is considered "inoperable" (called unresectable) for purposes of the listings. Carcinoma of the breast as described under Listing 13.09C is an exception. The length of time from radical surgery to recurrence does

not matter for purposes of allowance under the listings—years could pass between the original surgery and a recurrence of cancer. However, the time interval to recurrence could affect when the medical *onset* of disability is granted by the SSA.

How Doctors Tell If Cancer Is Removed

When a pathologist microscopically examines surgically removed tissue, such as a cancerous tumor, she carefully examines the area where the surgeon's scalpel cut. If this surgical margin has even microscopic cancer cells, then the surgeon may not have gotten all of the cancer and a wider removal of tissue will be required, if possible. This is why surgeons send specimens for frozen section evaluation by a pathologist while the patient is still on the operating table.

Later, the pathologist will use tissue stains to make more permanent slides and write a definitive, final report. In cases where the permanent, final microscopic examination shows any cancer cells still at the surgical margin, then the SSA must conclude that removal of the cancer was incomplete. For purposes of the listings where relevant, this means the cancer was "inoperable" or "unresectable" even though only microscopic amounts of cancer remain in the patient. Such cells are enough to cause a recurrent tumor and its progression. Under such circumstances, the SSA should not claim there is complete removal of a cancer.

Local recurrence of cancer in the area of a previously incomplete removal may still be cured with radical surgery. Therefore, recurrence of a still completely removable tumor is not the same as recurrence after radical surgery; recurrence after radical surgery has a grave prognosis. On the other hand, even the local recurrence of some cancers results in allowance under some listings. Also, the tissue type and site of involvement are not necessarily indicators of the degree of impairment in some cancers, such as the lymphomas. The specific listings for specific cancers take these facts into account in their requirements.

4. Duration of Disability for Cancer

In the adult listings, when the original tumor and any metastases have apparently disappeared and have not been evident for three or more years, the impairment cannot meet the criteria under any cancer listing. This also means, however, that the SSA will consider a claimant to be at the allowance level (eligible for benefits) for a minimum of three years. This is true even if the cancer has apparently disappeared in less than three years. This applies to new claims for disability and to beneficiaries already receiving

disability benefits. The "three year rule" also applies to "recurrent" cancer in those listings that specify recurrence as an allowance. Counting of time starts again from the date of recurrence.

In children, the duration of disability from cancerous tumors is included in child Listings 113.02 and 113.03. Following the time periods designated in the child cancer listings, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of the remaining impairment must be evaluated on the basis of the medical evidence. In those with no specified automatic allowance duration (child Listings 113.04 and 113.05), the SSA states that the disability "...must be evaluated on the basis of the medical evidence." This statement makes the duration of disability because of cancer a matter of medical judgment in Listings 113.04 and 113.05.

5. Other Impairments and Treatment Side Effects

Any remaining impairments present after treatment for cancer that are not considered under these listings, should be evaluated under whatever listings are appropriate for such persistent medical problems. Even if a cancer does not satisfy the requirements of a listing, the treatments may. Given that the resulting side effects vary widely among different people, each case must be considered on an individual basis. It is essential that the SSA obtain a description of the complications or any other adverse response to therapy such as nausea, vomiting, diarrhea, weakness, skin (dermatologic) disorders or mental disorders resulting from treatment. Since the severity of the side effects of anti-cancer chemotherapy may change during the period of drug administration, the decision regarding the impact of drug therapy should be based on a sufficient period of therapy to allow reasonable consideration of its effect on the claimant.

6. Onset of Disability in Cancer Cases

Cancers differ in their rate of growth. Some grow slowly over a period of many years and others are fatal in a few months. When the SSA has no evidence about a claimant's health before their diagnosis of allowance-level cancer, a reasonable medical onset must be established, if relevant to the case. To establish the medical onset of disability before the time a cancer is first shown to be inoperable or beyond control by other types of treatment requires medical judgment. This judgement must be based on medically reported symptoms, the specific type of cancer, the location of the cancer and the extent of cancer spread when first demonstrated to be present.

It is reasonable and common for the SSA to recognize a medical onset of someone's disability up to six months before the person was shown to have cancer where there is no prior evidence to permit a more accurate determination. However, this statement is not a formal regulation used by the SSA. Medical onset dates do not necessarily determine when benefits begin, since laws and nonmedical administrative rules and regulations also affect when benefits can start. See Chapter 10 for a discussion of onset.

As in other serious medical disorders, disability determinations involving cancer cases are far beyond the educational capacity of disability examiners, claim managers or other nondoctors working for the SSA. You should insist that your medical impairments be evaluated by a medical doctor or osteopath and that doctors are not merely signing off on documents given to them by nondoctors.

B. Specific Listings and Residual Functional Capacity

The listings that follow are in the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussion of residual functional capacity does not apply to children.

1. Listing 13.02: Head and Neck Cancer (Adults)

Head and neck cancers considered under this listing do not include brain tumors (Listing 11.05), salivary gland tumors (Listing 13.07), thyroid gland tumors (Listing 13.08) or tumors of the lower jawbone (mandible). Also, tumors of the upper jawbone (maxilla), eye socket (orbit) or area near the temporal bone of the skull (temporal fossa) are evaluated under another Listing (13.11). Most head and neck cancers are squamous cell carcinoma (SCC), also known as epidermoid carcinoma, and are usually caused by smoking or chewing tobacco. They can arise in the nose, sinuses, throat, gums, tongue or elsewhere in the mouth. Smoking and chewing tobacco can also contribute to the development of esophageal cancer, stomach cancer, colon cancer, bladder cancer and kidney cancer. These cancers are evaluated under other listings.

The pyriform sinus is a space in the back part of the throat and refers to either the right or left pyriform sinuses. Involvement of this area with cancer is an extremely poor

prognostic sign, since such cancers tend to be aggressive and also because there is good lymphatic drainage that can spread the cancer. The pyriform sinus cannot be seen by a routine examination of the mouth and throat using an ordinary tongue blade and light, because it is down just below the back of the tongue in an area of the throat called the hypopharynx. Cancer in the back (posterior) part of the tongue also has a poor prognosis, and that is why it is included here.

a. Listing Level Severity

For your condition to be severe enough to meet this listing you must have Ⓐ, Ⓑ, Ⓒ, Ⓓ or Ⓔ, below.

- Ⓐ Inoperable cancer.
- Ⓑ Cancer not controlled by prescribed therapy.
- Ⓒ Recurrent cancer in any degree after radical surgery or radiation treatment.
- Ⓓ Any amount of cancer that has spread too far for surgical removal of the entire cancer (distant metastasis).
- Ⓔ Squamous cell carcinoma occurring in the pyriform sinus or posterior third of the tongue.

b. Residual Functional Capacity

In people who have undergone a laryngectomy, the RFC must take into account how well artificial methods of speech can be learned. Some claimants can use an electronic device held to the side of the neck, about 20–40% can learn esophageal speech using air in the esophagus, and some patients receive implanted prostheses to help them speak. However, normal speech can never be achieved.

Claimants with removal of parts of the tongue, jaw or other facial structures may not only be disfigured, but have difficulty speaking. Surgical facial deformities, especially involving the mouth, can be associated with malnutrition because of an inability to eat normally.

Patients with head and neck cancer frequently require removal of lymph nodes in their neck in order to determine how far the cancer has spread. During surgery, the surgeon must be careful not to cut the right or left spinal accessory nerves to the muscles that help raise the shoulders. Some surgeons are more careful than others. If that nerve is cut, the ability to lift will be affected, especially regarding overhead lifting or sustained overhead work with the shoulder affected.

2. Listing 113.02: Lymphoma Cancer (Children)

Lymphoma refers to cancer of the lymph nodes and spleen that produces abnormal lymphocytes. Lymphoma can invade other organs of the body. Hodgkin's lymphoma

(Hodgkin's disease) and non-Hodgkin's lymphoma are two important classifications.

Hodgkin's lymphoma has a very good prognosis with treatment. Therefore, part Ⓐ, which deals with Hodgkin's lymphoma, requires not only that form of cancer but also that it not be controlled by prescribed therapy and that it be worsening (progressive).

Although many types of non-Hodgkin's lymphoma have a good prognosis, part Ⓑ of the listing grants a minimum of two and a half years of benefits from the time of diagnosis or date of recurrence. During this time, it does not matter how well the child is responding to treatment.

a. Listing Level Severity

The child's condition must match Ⓐ or Ⓑ, below.

- Ⓐ Hodgkin's disease with progressive disease not controlled by prescribed therapy.
- Ⓑ Non-Hodgkin's lymphoma. The SSA will automatically consider the child to be under a disability:
 1. For two and a half years from the time of initial diagnosis.
 2. For two and a half years from the time of recurrence of active disease at any time, of any degree or at any location.

3. Listing 13.03: Sarcoma of Skin (Adults)

The most common skin cancers are basal cell carcinomas (BCC) and squamous cell carcinomas (SCC). These cancers can be very destructive to tissue, but rarely metastasize and can be completely cured if diagnosed early. They are not sarcomas and are not considered under this listing, which deals with the far more serious angiosarcomas and mycosis fungoides.

Angiosarcomas are rare and dangerous cancers arising from blood vessels (hemangiosarcomas) or lymphatic vessels (lymphangiosarcomas). Angiosarcomas arising in the skin have a poor prognosis, with a nearly 90% death rate five years from diagnosis.

Mycosis fungoides (MF), of which there are several variants, such as the Sèzary syndrome, is a type of lymphoma cancer in which T-lymphocyte cells invade the skin. T lymphocytes are normally part of the body's immune system. In mycosis fungoides these T-lymphocytic cells are cancerous, but the cancer is of a low-grade kind and a patient may have itchy skin patches for up to ten years before the diagnosis is made. In other words, MF is a low-grade T-cell lymphoma. The median survival after diagnosis is ten years, and if there is only limited skin involvement a patient may die of other causes rather than mycosis fungoides. In the more advanced stages involving spread of MF to internal organs

(visceral involvement), median survival may drop to three years—usually from complications such as infection.

a. Listing Level Severity

The claimant's condition must match Ⓐ or Ⓑ, below.

- Ⓐ Angiosarcoma with spread to regional lymph nodes or beyond.
- Ⓑ Mycosis fungoides with spread to the regional lymph nodes or beyond them to internal organs.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and treatment given. Most cancers severe enough to cause substantial limitations would be an allowance under this listing without consideration of RFC. In those cases that do not meet the listing, it is important, during RFC consideration, to note that skin areas affected by treatment or cancer should not be exposed to any chemicals or excessive water.

4. Listing 113.03: Malignant Solid Tumors (Children)

Solid cancerous tumors in this listing do not include leukemia. This listing also does not include brain tumors (child Listing 111.05) or thyroid tumors. Any other solid cancers are evaluated under this listing. Examples include osteosarcomas of bone or soft tissue sarcomas such as those arising from muscle or the histiocytosis syndromes. The histiocytosis syndromes, also known as Langerhans cell histiocytoses (LCH), consist of eosinophilic granuloma, Letterer-Siwe disease and Hand-Schüller-Christian disease. Bones and skin are particularly likely to be involved with these disorders, but other organs such as the liver and lungs may also be affected. However, you don't have to understand these histiocytosis cancers to know that if a child is diagnosed with one of them, the child will be allowed benefits under this listing. The SSA states that an exception is a solitary eosinophilic granuloma tumor, which cannot qualify under the listing.

a. Listing Level Severity

For children with this condition, the SSA will either

- Ⓐ Consider the child disabled for two years from the time of initial diagnosis, or
- Ⓑ Consider the child disabled for two years from the time of recurrence of active disease at any time, in any degree or any location.

5. Listing 13.04: Sarcoma of Soft Parts (Adults)

Sarcomas of soft parts are any type of connective tissue cancer that does not include bone. Possible examples include sarcomas of muscle (for example, leiomyosarcoma, rhabdomyosarcoma), sarcomas of synovial membranes (synovial cell sarcoma) and sarcomas of fatty tissue (liposarcomas).

Sarcomas are generally very dangerous cancers. Treatment can involve surgery (including amputation of a limb), chemotherapy and radiotherapy. Such claims must be evaluated on the basis of all the facts in a particular case, including the type of sarcoma, history and response to treatment and prognosis. Whether a sarcoma is controlled with prescribed therapy is a matter of medical judgment. However, any distant metastasis is not likely to be controlled and should meet the listing. There could be exceptions, such as a single metastatic tumor that is removed along with the primary tumor. Consideration would also have to be given to the type of cancer involved—more aggressive types of sarcoma should be considered more leniently for meeting the listing. For example, a person might have a low-grade malignancy like synovial cell sarcoma that is compatible with a long life; alternatively, one might have an aggressive cancer of a thigh muscle—a rhabdomyosarcoma. Informed medical judgment would not look at these cancers in the same way.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have sarcoma of soft parts that is not controlled with prescribed therapy.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and treatment given. For example, amputation of an arm or leg in an attempt to remove all of a sarcoma before it spreads would require consideration. Removal of an arm restricts a claimant to one-armed light work. If damage to a lower extremity (leg or thigh) is so great that the claimant cannot stand and walk for at least six hours daily, then a residual function capacity (RFC) cannot be higher than sedentary work. For example, synovial cell cancer in a knee joint and treatment for it can affect the ability to walk, stand and use leg controls. A rhabdomyosarcoma excised from a thigh muscle is likely to take a lot of muscle tissue with it; even if there is a cure, that leg muscle strength is going to be affected.

6. Listing 113.04: Neuroblastoma (Children)

Neuroblastoma is one of the most common cancers of infancy. It is caused by chromosomal abnormalities involving a part of the nervous system. The most frequent organs affected are the adrenal glands. The prognosis is better if the child is less than one year of age.

a. Listing Level Severity

To be severe enough to meet the listing, the child's condition must match **A**, **B**, **C** or **D**, below.

- A** Extension of cancer from one side of the body to the other (across the midline of the body).
- B** Cancer that has spread too far for surgical removal of the entire cancer (distant metastasis).
- C** Recurrence of cancer at any time, in any degree or any location.
- D** Onset at one year of age or older.

7. Listing 13.05: Malignant Melanoma (Adults)

Malignant melanoma is a very dangerous form of cancer usually starting as a pigmented (dark) spot on the skin. Rare forms are not pigmented and are known as amelanotic melanoma. Most little spots on the skin are harmless, but melanoma spreads rapidly to internal organs and is very difficult to control. With increasing exposure to sunlight the risk of melanoma increases. Melanomas often occur on the back, but could be anywhere, including the face. Unlike most freckles or other harmless dark spots on the skin, melanomas tend to have variations in color and more uneven edges. Melanoma is now the seventh most common cancer and its incidence continues to increase. About 75% of skin cancer deaths are caused by melanoma, although it accounts for only a small percentage of skin cancers overall. Most skin cancers are basal cell carcinoma (about 80%) and squamous cell carcinoma (about 15%), but these cancers are not nearly as deadly as melanoma.

Anyone with a colored (pigmented) skin abnormality should see a skin specialist (dermatologist) if that lesion is rapidly growing, irritated or painful, having multiple shades of color, has an irregular border or is asymmetric in shape. Ninety percent of melanomas can be diagnosed by visual examination by an experienced dermatologist, but a biopsy is necessary for definitive diagnosis. A small delay in proper diagnosis can mean the difference between life and death, because even the smallest depth of invasion of the cancer into the layers of the skin strongly affects the probability of the melanoma spreading to other locations in the body. If the diagnosis of melanoma can be made while the cancer has invaded less than the tiny distance of 1 millimeter into

the dermal layer of the skin, a 90% cure rate can be obtained. Once metastasis occurs, the prognosis is truly grim. Time is critical, because even a small harmless looking melanoma on the skin may have already spread extensively throughout the body. With a suspicious skin lesion, it is folly to wait and see what happens next. When there is distant metastasis, many patients will be dead within three years.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, you must have Ⓐ or Ⓑ, below.

- Ⓐ Recurrent cancer at any time, in any degree or any location, after removal of the original melanoma with a wide surgical excision around the tumor.
- Ⓑ Any spread of cancer to other areas of skin around the primary melanoma skin tumor (satellite lesions) or any other metastasis to any location in the body outside of the primary tumor.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and treatment given. If a melanoma were diagnosed early enough to be removed completely, it is quite possible that there would be no significant residual impairment. If claimant has survived three or more years without further evidence of cancer, they would no longer qualify under the listing and might require an RFC. For example, there are people who have an arm amputated because of melanoma. They would be able to do no more than light work. Others may have had a leg or foot amputated and might not be able to stand six to eight hours daily or use leg controls. The most common eye cancer is a melanoma. If you had melanoma in an eye that had to be removed, then you would not be able to perform jobs requiring good peripheral vision—such as working at unprotected heights or around hazardous machinery.

8. Listing 113.05: Retinoblastoma (Children)

Retinoblastoma is an eye tumor in children, almost always appearing before four or five years of age. It can be genetic in origin or acquired. Prognosis for survival is generally good, though loss of vision is common. Removal of the affected eye (enucleation) may be required in some cases.

a. Listing Level Severity

To be severe enough to meet the listing, the child's condition must match Ⓐ, Ⓑ, Ⓒ or Ⓓ, below.

- Ⓐ Involvement of both eyes with retinoblastoma.

- Ⓑ Metastasis of any degree to any location.
- Ⓒ Direct growth of the tumor (extension) to any location beyond the orbit.
- Ⓓ Recurrence at any time, in any degree or any location.

9. Listing 13.06: Cancer in Lymph Nodes (Adults)

The lymphatic system of the body does not carry blood. It consists of small tubes carrying lymph fluid and is important in keeping excess fluid from building up in certain areas of the body. For example, blockage of lymphatic vessels in the legs will result in swelling. Large numbers of lymph nodes can be found in the axillae, neck and around the intestines. But they are also found in many other locations.

Lymph nodes are specialized collections of cells found in various locations along the system of lymph vessels. Lymph nodes function for the immune system and contain lymphocytes. For example, lymph nodes can trap and destroy bacteria.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must match Ⓐ, Ⓑ or Ⓒ, below.

- Ⓐ Hodgkin's disease or non-Hodgkin's lymphoma, with progressive disease that is not controlled with prescribed therapy. Lymphoma is cancer of the lymph nodes and spleen that produces abnormal lymphocytes. However, lymphoma can invade any organ of the body. Advanced lymphomas can result in death, but they usually respond much better to treatment with drugs than other forms of cancer. Lymphomas are the least dangerous of all the malignancies in the cancer listings. Hodgkin's lymphoma and non-Hodgkin's lymphoma are two important classifications. Hodgkin's lymphoma (Hodgkin's disease) is less dangerous than non-Hodgkin's lymphoma, but both often respond well to treatment. There are further classifications of non-Hodgkin's lymphoma by the exact type of lymphocytes involved. This listing requires progressive lymphoma, not just a lymphoma that is still present despite treatment. This can sometimes be a very difficult medical judgment to make. If you have lymphoma and are thinking of applying for disability benefits, discuss with your treating doctor whether your cancer is worsening. If the answer is "yes," ask that your doctor clearly state the reasons he or she feels the lymphoma is worsening, either in a letter to the SSA or in your medical records where the SSA can see the information. Certainly, lymphoma appearing in new locations during treatment would have to be considered progressive.

ⓑ Metastatic carcinoma in a neck lymph node, provided that:

- The primary tumor cannot be found after an adequate search, and
- The lymph node does not contain epidermoid carcinoma (squamous cell carcinoma, SCC).

This part of the listing concerns non-lymphoma cancer in lymph nodes. Lymph nodes may contain cancerous cells that are being spread through the lymphatic system from cancer anywhere in the body. For example, colon cancer might spread to a lymph node somewhere else in the abdomen. That is why biopsy of lymph nodes around cancerous tumors is important in determining whether cancer has metastasized from the original tumor through the lymphatic system. To perform such a biopsy, lymph nodes are surgically removed. The presence of cancer in a lymph node in the neck is an assurance that there is a malignant tumor somewhere in the body and, if it cannot be found, then the prognosis is much worse. An exception is made for epidermoid carcinoma in the neck, which is considered in part ⓒ.

ⓒ Epidermoid carcinoma in a lymph node in the neck that is not responding to prescribed therapy.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and treatment given. Removal of lymph nodes may cause no difficulties. In other instances, removal of large numbers of lymph nodes may result in some swelling in the part of the body normally drained of lymph fluid along the path of those nodes. Most RFCs apply to lymphoma that is present, but not progressive as required by the listing.

10. Listing 13.07: Salivary Gland Cancer (Adults)

The major salivary glands are the parotid, sublingual and submandibular glands. These are paired, right and left glands. The parotid glands are on the sides of the face, the sublingual glands are under the tongue and the submandibular glands are under the lower jaw.

It is important to know the names of some cancerous and noncancerous salivary gland tumors, in order to understand those that might be an allowance under this listing. There are many types of salivary gland cancer that vary in their degree of malignancy. For example, mucoepidermoid carcinomas and acinic cell carcinomas are usually low-grade cancers that can be treated for cure or long-term survival, while there are poorly differentiated and highly malignant carcinomas that will kill the majority of patients within five

years. Treatment of salivary gland cancers involves surgical removal of the gland affected and may also involve radiation therapy.

Noncancerous salivary gland tumors include Warthin's tumor (papillary cystadenoma lymphomatosum), oncocytomas, monomorphic adenomas, benign lymphoepithelial tumors and benign mixed tumors (pleomorphic adenomas). These tumors cannot be considered under this listing.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have any carcinoma or sarcoma type cancer of any salivary gland that has spread beyond your regional lymph nodes (distant metastasis).

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and the treatment given. Highly malignant parotid gland tumors may involve bone, skin and the facial nerve. Damage to the facial nerve can produce facial paralysis of that side of the face. The ability to stand, walk, lift or carry would not be affected by salivary gland cancer although during the period of treatment these activities could be limited by the side effects of treatment in the form of drugs or radiation.

11. Listing 13.08: Thyroid Gland Cancer (Adults)

The thyroid gland makes thyroid hormone and is located in the front of the neck. Normally a doctor cannot feel the thyroid gland during physical examination of the neck, but a nodule such as a cancer might be felt. An enlarged thyroid gland is called a goiter and can be very prominent, but goiters do not mean cancer is present. The cancers of the thyroid are various types of carcinoma that differ in their degree of malignancy. Overall, about 90% of patients will survive the cancer, including those with late stages of cancer. Papillary and follicular carcinomas are the most common. There are also less frequent medullary and anaplastic (nondifferentiated) carcinomas, which are more serious. Most thyroid cancer can be controlled with treatment, even when there is metastasis to other parts of the body, such as the lungs. There are exceptions, but most thyroid cancers can be cured. Only a minority of cases qualify under the listing.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have Ⓐ or ⓑ, below.

- Ⓐ Anaplastic carcinoma, or any carcinoma not controlled by prescribed therapy.
- Ⓑ Any thyroid carcinoma cancer that has spread beyond the regional lymph nodes (distant metastasis) and that is not controlled by prescribed therapy.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and treatment given. However, RFC is not usually an issue in thyroid cancer cases, because, if they are successfully treated, there is usually no residual impairment and if they are not successfully treated they meet the listing.

12. Listing 13.09: Breast Cancer (Adults)

Breast cancer is a very serious malignancy occurring in women and, rarely, men. It is one of the most frequent types of cancer seen by the SSA and so you should have a good understanding of how the SSA evaluates such claims. The most common type of breast cancer is infiltrating ductal carcinoma, accounting for about two-thirds of cases. Some other types in order of frequency in which they occur include lobular carcinoma, medullary carcinoma, colloid carcinoma, comedocarcinoma and papillary carcinoma. About 1% of breast cancers also involve Paget's disease, which is itching of the nipple with scaling skin changes associated with some combination of oozing, burning or bleeding from the nipple. In Paget's disease, these abnormalities are caused by invasion of the nipple with cancer that can often be felt in the breast during physical examination. Breast sarcomas are much less common than carcinomas and are also considered under this listing in Part Ⓔ.

Regular mammograms are important in the early detection of breast cancer, although authorities differ on exactly how often such tests should be done. In addition to the usual x-ray mammograms that most women receive, there are other breast imaging techniques that can help doctors better see inside the breast. These include high frequency sound (ultrasound), heat patterns from the breast (thermography), transillumination of the breast with light, magnetic resonance imaging (MRI) and computerized axial tomography (CAT scans). Despite the number of imaging techniques available for detecting suspicious masses in the breast, biopsy is the only way to obtain an accurate diagnosis.

As in other cancers, early detection is the key to survival of breast cancer, since there is less probability that the cancer has spread to locations that cannot be surgically removed for cure (distant metastasis). Fortunate women with small early cancers might need only a lumpectomy. In these cases surgical reconstruction of the breast might leave

little cosmetic deformity. Others may require removal of the entire breast, along with the underlying chest muscles—radical mastectomy. If distant metastasis appears to have occurred, chemotherapy will also be given, but the probability of cure falls drastically when the tumor has spread and cannot be completely removed surgically.

Inflammatory carcinoma (part Ⓑ) is associated with breast inflammation: swelling of the skin (edema), warmth of the skin to touch, erythema and induration of the skin. A breast lump may also be felt in about half the cases. These are clinical abnormalities and not sufficient for a definitive diagnosis, which must be based on the microscopic evaluation of a skin biopsy specimen that specifically shows invasion of cancer cells into the lymphatic vessels in the skin of the breast area concerned. Inflammatory carcinoma occurs in about 1–5% of breast carcinomas. It has a poor prognosis, even if there is no evidence of metastasis at the time of diagnosis.

The axillary lymph nodes are critically important in the staging of breast cancer, because they are the first nodes that receive drainage from the breast. If the axillary nodes are positive for cancer, there is a greater chance that the cancer has spread past them (distant metastasis). However, spread to the axillary nodes themselves is not distant metastasis and does not qualify as such under this listing. Also, when breast cancer occurs in both breasts, it is usually not because of distant metastasis from one breast to the other, but two separate primary cancers (part Ⓓ).

Men can have breast cancer and their prognosis is similar to that of women. The risk is higher when the man has female relatives with breast cancer, radiation exposure, a parasitic infection known as schistosomiasis and the genetic disorder of Klinefelter's syndrome.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must match Ⓐ, Ⓑ, Ⓒ, Ⓓ or Ⓔ, below.

- Ⓐ Inoperable carcinoma.
- Ⓑ Inflammatory carcinoma.
- Ⓒ Recurrent carcinoma at any time, in any degree or any location except a local recurrence at the site of the original breast cancer that is controlled with prescribed therapy.
- Ⓓ Carcinoma cancer that has spread too far for surgical removal of the entire cancer (distant metastasis).
- Ⓔ Sarcoma cancer with any number of metastases anywhere.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and the treatment given. However, several specific complica-

tions of breast cancer surgery that can affect residual functional capacity (RFC) can be mentioned. If only a simple mastectomy is done, then only the breast is removed and none of the underlying chest muscles. This is a slight (not severe) impairment that doesn't produce any significant restrictions on ability to function. If a radical mastectomy is done, removal of the underlying chest muscles can very easily restrict strength enough to preclude heavy lifting. Another potential problem is that if most of the axillary lymph nodes have been removed, then inadequate drainage of lymph fluid from the arm can result in swelling that is quite troubling to the claimant and could affect the ability to use that arm normally.

13. Listing 13.10: Skeletal System Cancer (Adults)

This listing involves any type of cancer affecting bone, except cancer of the jaw, which is considered under Listing 13.11. There are two ways cancer can involve bone: cancer arising from the bone itself (primary tumors of bone) and cancer that has spread to bone from a tumor originating elsewhere in the body.

An important primary bone tumor is osteosarcoma, which is a highly cancerous growth. Such a tumor would satisfy part ① of the listing if it gave off cancerous cells that spread elsewhere in the body, including to other bones. Part ① has the additional requirement that it “not (be) controlled by prescribed therapy.” If osteosarcoma produced one or two metastases that could be removed along with the primary bone tumor, the impairment would fail to meet part ①. However, that is usually not the case. Certainly, multiple metastatic lesions or even one metastatic lesion that can't be eliminated would qualify under part ①.

Part ② of the listing is satisfied by any type of carcinoma that spreads to bone from elsewhere in the body. Examples of cancers that may metastasize to bone include prostatic cancer, breast cancer, kidney cancer and lung cancer. These are all very dangerous cancers, particularly breast, kidney and lung cancer that have spread to bone. Single bone lesions from these cancers are easier to deal with than multiple metastatic lesions spread widely throughout the skeletal system. For instance, it might be possible to remove a single metastatic tumor surgically or treat it with radiation, whereas neither of these options would be possible with a large number of metastatic bone lesions. However, even if there is only one metastatic bone cancer tumor, inability to find the primary tumor from which it originated is ominous, since it will continue to give off cancerous cells that could then go anywhere in the body. Such cancer is frequently found first as a bone lesion that produces a frac-

ture or pain and causes a patient to seek medical attention, but in most cases the primary tumor can be found because the cells can be identified as having an origin in a certain kind of organ. Although cases in which the original tumor is located cannot be evaluated under part ②, they would be evaluated under whatever listing is appropriate for that type of cancer. For example, a claimant has bone pain and is found to have a lesion in the spine. Biopsy of the lesion shows cells from prostate cancer. The prostate cancer is then treated. In this instance, evaluation would be done under Listing 13.23 for prostate cancer. On the other hand, if a tumor in a bone is biopsied but the cells don't appear to be of a particular type—such as breast cancer or kidney cancer—it may not be possible to find the primary tumor and part ② would be satisfied.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match ① or ②, below.

- ① Malignant primary tumors with evidence of metastases and not controlled by prescribed therapy.
- ② Metastatic carcinoma to bone where the primary tumor is not found after an adequate search.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and treatment given. In bone lesions, particular attention should be given to how treatment affects the structural integrity of the bones involved. If joint spaces are compromised either by tumor or treatment, an arm or leg could suffer functional loss. Similarly, a cancer could cause collapse of a vertebra with back pain and decreased ability to lift and bend, even if the tumor itself is successfully treated.

14. Listing 13.11: Cancer of the Mandible, Maxilla, Orbit or Temporal Fossa (Adults)

This listing deals with cancer in the lower jaw (mandible), upper jaw (maxilla) orbit (eye socket) or sides of the skull (temporal fossa). Several forms of cancer may be involved.

Part ① is satisfied by sarcoma type cancer, of which osteosarcoma is the most common considered under this listing. Osteosarcomas arising from the temporal bones could also be considered under part ①. Another possible sarcoma in these bones is an adamantinoma, also known as an ameloblastoma. Adamantinomas rarely metastasize and are more likely to satisfy part ② of the listing than part ①.

Sinuses are cavities in the facial bones. The “antrum” (part ②) refers to either of the maxillary sinuses, which are

located in the facial bones just to the right or left sides of the nose. Carcinoma in this sinus can spread to other sinuses, the orbit or more distant locations. These are usually squamous cell carcinomas caused by cigarette smoking or dipping snuff.

Cancers of the orbit qualifying under part © could be cancers arising from the bones forming the walls of the eye socket, from the eye itself or other soft tissues around the eye.

Rathke's pouch (part ⑤) is the embryonic structure from which the anterior part of the pituitary gland is formed. Remnants of Rathke's pouch that sometimes remain after development of the pituitary gland may give rise to tumors known as craniopharyngiomas. Tumors arising from the anterior part of the pituitary gland itself could also potentially qualify under part ⑤.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match part ④, ⑤, ⑥, ⑦, ⑧ or ⑨, below.

- ④ Sarcoma of any type with metastases.
- ⑤ Carcinoma of the antrum with extension into the orbit or ethmoid or sphenoid sinus or with regional or distant metastasis.
- ⑥ Any cancer of the orbit with direct growth into the inside of the skull (intracranial infiltration or extension).
- ⑦ Tumors of the temporal fossa that erode through the skull and involve the meningeal membranes covering the brain.
- ⑧ Adamantinomas that grow into the orbit or into the inside of the skull (intracranial infiltration or extension).
- ⑨ Tumors of Rathke's pouch that either directly grow into the base of the skull or have regional or distant metastasis.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and treatment given. The cancers in this listing involve the face, so they are not likely to produce restrictions on the amount of weight that can be lifted or the amount of standing or walking that you can do. If vision in one eye is affected, then you would not be able to perform jobs requiring good peripheral vision—such as working at unprotected heights or around hazardous machinery. However, cancers so advanced that they produce significant limitations would probably qualify under the listing without any need to consider RFC. Cosmetic deformity is one of the main problems with treatment of these cancers, if extensive surgery involving the face is required. However, physical

appearance is not something that significantly limits the ability to work at most jobs.

15. Listing 13.12: Cancer of the Brain or Spinal Cord (Adults)

This listing in part ④ concerns carcinoma-type cancers that metastasize to the brain or spinal cord from primary tumors arising from other locations in the body. Many carcinomas can spread to the brain or spinal cord, such as those from the kidney, lung, breast or colon. It is not reasonable that the SSA require a brain biopsy to prove a cancer has metastasized to the brain. It is sufficient to have proof of the original tumor (such as lung cancer) and reasonable evidence of a metastatic lesion by imaging techniques such as computerized axial tomography (CAT) scans or magnetic resonance imaging (MRI) of the brain or spinal cord. It should be emphasized that even if there is a small metastatic cancer affecting the brain that is successfully treated, you can still qualify under part ④.

Part ⑤ refers evaluation to Listing 11.05 for primary brain cancers and to Listing 11.08 for cancers that start in the spinal cord.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match ④ or ⑤, below.

- ④ Metastatic carcinoma of the brain or spinal cord.
- ⑤ Other tumors, evaluated under the criteria described in Listing 11.05 and Listing 11.08.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account your residual impairment from both the cancer and the treatment given. Cancers that involve the brain and spinal cord may produce neurological abnormalities such as weakness, paralysis, seizures and instability of gait (depending on their location). Additionally, the SSA should give attention to psychological changes that can accompany brain tumors and also damage to the brain from treatment. These considerations may require a separate psychological evaluation.

16. Listing 13.13: Lung Cancer (Adults)

The SSA sees large numbers of claimants with lung cancer, almost always associated with a history of cigarette smoking. Most frequently, the cancer is squamous cell carcinoma (SCC), also known as epidermoid carcinoma, occurring in the bronchial tubes. There are also significant numbers of

adenocarcinomas in claimants with histories of cigarette smoking. These cancers are very dangerous, and a person's best chance of cure is if the cancer is detected early enough to allow complete surgical removal. Once there is distant metastasis of the cancer to other organs the prognosis is grim. Another, often fatal, form of lung cancer is small cell cancer, also known by the older name of oat cell carcinoma.

The location where lymphatic vessels, arteries and veins enter each lung is called the hilum. The associated lymph nodes are called hilar lymph nodes (parts ④, ⑤) and are important markers in determining how far a lung cancer has spread, which influences prognosis and planned treatments. The mediastinum is the large space between the lungs that contains the heart, esophagus, trachea, lymph nodes and other structures. Spread of lung cancer to lymph nodes in the mediastinum is more distant than the hilar nodes and should be considered unresectable for purposes of part ④. Mediastinal metastasis is also beyond the hilar lymph nodes for purposes of part ⑤.

Recurrence of cancer (part ⑥) means recurrence of the original cancer, not of any other new cancer. The presence of small cell carcinoma is sufficient for allowance (part ⑤), without consideration of the claimant's condition or response to treatment, because initial favorable responses to treatment are not likely to last.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match ④, ⑤, ⑥, ⑦ or ⑧, below.

- ④ Unresectable or with incomplete excision.
- ⑤ Any recurrence of cancer, in any degree, at any time, anywhere in the body after resection.
- ⑥ Oat cell (small cell) carcinoma.
- ⑦ Squamous cell carcinoma, with metastases beyond the hilar lymph nodes, after resection of the primary tumor.
- ⑧ Other cell types of carcinoma, including undifferentiated and mixed-cell types, with metastases to the hilar lymph nodes. Excluded are oat cell carcinoma (part ⑥) and squamous cell carcinoma (part ⑦).

b. Residual Functional Capacity

People with lung cancer frequently have lung disease, especially emphysema and chronic bronchitis associated with cigarette smoking. The limiting effects of such disease must be taken into consideration even if the claimant is not allowed benefits on the basis of cancer. Also, breathing capacity is diminished in some degree when parts of a lung are removed (lobectomy), significantly so when an entire lung is removed (pneumonectomy). If not an allowance under the listings dealing with breathing impairment, the

residual functional capacity (RFC) should always include restrictions against exposure to excessive dust and fumes when lung disease is present. The SSA should always evaluate breathing capacity with appropriate pulmonary function tests when lung disease other than cancer is present, if the cancer listing is not satisfied. Some such claimants could meet a breathing disorder listing or might be a medical-vocational allowance under one of those listings, even though their cancer doesn't qualify under this listing for cancer. (See Chapter 18 for a discussion of breathing disorders.)

17. Listing 13.14: Cancer of the Pleura or Mediastinum (Adults)

The pleura is a moist membrane that covers the outside of the lungs and the inside of the chest cavity. The mediastinum is the large space between the lungs that contains the heart, esophagus, trachea, lymph nodes and other structures.

A mesothelioma is a tumor originating in the pleura and may be either benign or cancerous. Excessive exposure to asbestos is a known cause of malignant mesothelioma.

Because of the structures in the mediastinum, a large number of possible cancers can affect this area. Some examples include lung cancer, malignant mesothelioma, lymphoma, endocrine tumors, sarcomas, esophageal cancers, neurogenic tumors arising from nerve tissue, seminomas and others. All of these cancers vary in treatment and prognosis.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match part ④, ⑤ or ⑥, below.

- ④ Malignant mesothelioma of the pleura.
- ⑤ Malignant tumors of any kind, at any location in the body, with metastases to the pleura.
- ⑥ Malignant tumors originating the mediastinum that are not controlled by prescribed therapy.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and the treatment given. When a pleural cancer is involved, surgical resection of part of the chest wall may result in a breathing impairment that needs additional evaluation. (See Chapter 18 for a discussion of breathing disorders.)

18. Listing 13.15: Cancer in the Abdomen (Adults)

The abdomen is that part of the body that lies between the chest and the pelvis. Cancer affecting the abdomen can

arise in the kidneys and associated structures, bladder, intestine, liver, pancreas, stomach, ovaries, uterus or fallopian tubes. These organs can all produce carcinoma type cancers. There are specific listings for these forms of cancer. This listing covers some general problems with abdominal cancer that may be common to many types of cancer.

Generalized carcinomatosis (part Ⓐ) refers to a spread of carcinoma cancer throughout the abdominal cavity. This is an inoperable and deadly condition, regardless of the type of cancer. For example, a colon carcinoma could spread to the bottom surface of the liver and over the surface of the peritoneal membrane lining the abdominal cavity. Ovarian cancer could do the same thing. With so many implants of cancer spread throughout the abdomen, such generalized carcinomatosis cannot be treated by surgical removal of all of the cancer.

The retroperitoneal area of the abdomen (part Ⓑ) can give rise to a number of cellular sarcoma cancers, including muscle sarcomas (leiomyosarcomas and rhabdomyosarcomas), fibrous sarcomas (fibrosarcomas), fatty sarcomas (liposarcomas), angiosarcomas (hemangio- and lymphangiosarcomas) and others.

Ascites refers to an abnormal accumulation of fluid in the abdomen. A frequent cause of ascites is liver failure associated with alcoholism. However, cancer can also be a cause, especially cancer of the ovaries that may result in ascites containing cancer cells (part Ⓒ). Cancerous cells can be demonstrated by taking a sample of the ascites and examining it microscopically.

Failure to satisfy this listing in no way prevents possible allowance under listings for specific cancers in abdominal organs, such as colon or ovarian cancer.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match part Ⓐ, Ⓑ or Ⓒ, below.

- Ⓐ Generalized carcinomatosis.
- Ⓑ Retroperitoneal cellular sarcoma that is not controlled with prescribed therapy.
- Ⓒ Ascites containing demonstrated malignant cells.

b. Residual Functional Capacity

If this listing is not satisfied, see the consideration of RFC under whatever listing is appropriate to the type of cancer present, response and side effects to treatment and any other applicable complications.

19. Listing 13.16: Cancer of the Esophagus or Stomach (Adults)

About 90% of esophageal cancer cases are squamous cell carcinoma (SCC) associated with exposure to alcohol and swallowed juices from tobacco products. Metastasis has often occurred by the time the cancer is diagnosed, so that about half the cases are already incurable by the time treatment can even start. There are also sarcomas that arise from muscles within the esophagus, and this cancer also has poor survival rates.

Over 90% of stomach (gastric) cancers are adenocarcinomas. The prognosis for survival is grim. At five years after diagnosis many patients will be dead, because most are not diagnosed early in the development of cancer. The lucky patients are those who receive an early diagnosis and total surgical removal of the cancer before it can spread; most will be alive five years after diagnosis. Surgery is the only curative treatment, and to be cured, must occur before the cancer can spread out of the stomach. Like esophageal cancer, exposure of the stomach to tobacco products is a risk factor for developing adenocarcinoma. Sarcomas can arise from the muscles of the stomach, but such cancers are rare compared to adenocarcinoma. Sarcomas of the stomach are dangerous cancers. As with stomach carcinomas, the only real hope for cure is early detection, before the malignancy can leave the stomach. After the sarcoma metastasizes, control becomes much less likely.

Note that regarding part Ⓐ, it doesn't matter how advanced the cancer is or how apparently successful the treatment. Part Ⓓ is mostly relevant to inoperable carcinoma of the stomach, since carcinoma in the esophagus, whether operable or not, is an allowance under part Ⓐ.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must satisfy Ⓐ, Ⓑ, Ⓒ, Ⓓ or Ⓔ, below.

- Ⓐ Carcinoma or sarcoma of the esophagus.
- Ⓑ Carcinoma of the stomach with metastases to regional lymph nodes or to more distant locations or extension into structures outside the stomach.
- Ⓒ Sarcoma of the stomach not controlled by prescribed therapy.
- Ⓓ Inoperable carcinoma.
- Ⓔ Any recurrence of any type of esophageal or stomach cancer, in any degree, at any time, anywhere in the body after surgical removal.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and the treatment given. Cancer in general can result in nutritional problems, but extensive surgery on the esophagus, stomach or surrounding structures may result in more difficulties in maintaining normal body weight. This fact could influence the residual functional capacity or even result in allowance under the digestive system listings if the weight loss is sufficiently great (see Chapter 20).

20. Listing 13.17: Cancer of the Small Intestine (Adults)

While cancer of the colon is a major killer of adults, cancer of the small intestine is rare. About half of small intestinal cancers are adenocarcinomas, but sarcomas can arise from the muscles in the intestinal wall. Other possible cancers of the small intestine are lymphomas and carcinoid. In general, small intestinal cancers produce symptoms of abdominal pain, nausea and vomiting. Carcinoid is the cause of about a third of small intestinal cancers and can produce chemicals like serotonin that result in more symptoms. Serotonin can cause what is called the carcinoid syndrome, with flushing of the skin and diarrhea. Carcinoid can also produce a number of other hormones and can arise in locations other than the small intestine.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must match **A**, **B** or **C**, below.

- A** Carcinoma, sarcoma or carcinoid tumor with spread beyond the regional lymph nodes (distant metastasis).
- B** Any recurrence of carcinoma, sarcoma or carcinoid tumor, in any degree, at any time, anywhere in the body after surgical removal.
- C** Sarcoma that is not controlled by prescribed therapy.

b. Residual Functional Capacity

The comments about RFC under Listing 13.16 apply here.

21. Listing 13.18: Cancer of the Large Intestine (Carcinoma or Sarcoma) (Adults)

Cancer of the large intestine in middle-aged and older adults is a major cause of cancer deaths. High-fat, low-fiber food with inadequate consumption of fruits and vegetables are risk factors for developing colon cancer of the adenocarcinoma type. Recently, evidence has added cigarette

smoking as a risk factor. Symptoms of abdominal pain, rectal bleeding or constipation may be present. The large intestine includes the rectum when considering this listing.

Over 90% of colon cancers are of the adenocarcinoma type and at least 10% have metastasized at the time of diagnosis. Like other cancers, the probability of being able to survive adenocarcinoma of the colon depends on whether it has spread. If the cancer is detected early, before any metastasis to even regional lymph nodes, then the five-year survival rate is about 95%. However, if the cancer has spread to distant sites, such as the liver, then five-year survival rates fall drastically. Long-term survival depends on the degree of malignancy of the individual cancer, as well as its location in the large intestine.

The listing also mentions sarcomas of the large intestine, but they are very rare. If a sarcoma is present, it is a dangerous tumor and has the same listing requirements.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must satisfy **A**, **B** or **C**, below.

- A** Inability to surgically remove the cancer for cure (unresectable).
- B** Metastases beyond the regional lymph nodes.
- C** Any recurrence of carcinoma or sarcoma, in any degree, at any time, anywhere in the body after surgical removal.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and treatment given. Because of the location of their colon cancer, some claimants have a permanent colostomy placed for removal of their intestinal bodily wastes. The SSA does not see the presence of a properly functioning colostomy as a problem that would limit exertional or other abilities. It is not unusual for a claimant with colon cancer that is completely removed surgically to recover well and have no functional limitations.

22. Listing 13.19: Cancer of the Liver or Gallbladder (Adults)

Primary malignant tumors of the liver are those that arise in the liver. About 90% of these cancers are hepatocellular carcinomas, which are associated with a dismal long-term survival rate even if they haven't obviously metastasized at the time of diagnosis. The liver is also an organ at high risk for receiving metastatic cancer cells from primary tumors arising in other locations, such as the colon, pancreas, kidney, breast, stomach, lung and ovary (part **A**).

Carcinoma arising in the gallbladder (part Ⓑ) or bile ducts (part Ⓒ) is very uncommon compared to colon cancer. The gallbladder stores bile manufactured in the liver. The bile ducts carry bile from the gallbladder and from the liver to the small intestine. These carcinomas are extremely dangerous, with poor survival rates.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match Ⓐ, Ⓑ or Ⓒ, below.

- Ⓐ Primary or metastatic malignant tumors of the liver.
- Ⓑ Carcinoma of the gallbladder.
- Ⓒ Carcinoma of the bile ducts.

b. Residual Functional Capacity

RFC has little relevance to this listing, since the presence of any of the listed cancers results in allowance of benefits, without consideration of other factors like response to treatment.

23. Listing 13.20: Cancer of the Pancreas (Adults)

Pancreatic cancer is of the carcinoma type, usually adenocarcinoma. Many cases are inoperable for cure at the time of diagnosis and most patients die within one year. Therefore, part Ⓐ is automatically satisfied by the diagnosis of pancreatic carcinoma. The one exception is islet cell carcinoma, which arises in the cells that normally produce the hormones insulin and glucagon, which must be evaluated under part Ⓑ.

One type of islet cell carcinoma is known as an insulinoma, because it produces abnormal amounts of the hormone insulin. However, most insulinomas are not cancerous; those that are malignant should be considered under part Ⓑ. Islet cell carcinomas may also produce a number of active hormones other than insulin.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match Ⓐ or Ⓑ below.

- Ⓐ Pancreatic carcinoma (except islet cell carcinoma).
- Ⓑ Pancreatic islet cell carcinoma, that is inoperable for cure and that produces some type of active hormone.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the

cancer and treatment given. Some cases of pancreatic islet cell carcinoma that don't secrete active hormones might be associated with residual problems after surgery on the pancreas to remove the cancer. For example, diabetes might result from removal of pancreatic tissue, and there could also be problems with digestion if sufficient pancreatic enzymes do not remain. See Chapter 20 regarding digestive disorders and Chapter 24 regarding diabetes. In fact, one of these listings might be met even if the criteria of the above cancer listing are not satisfied.

24. Listing 13.21: Carcinoma of the Kidneys, Adrenal Glands or Ureters (Adults)

One adrenal gland is located on top of each kidney. The ureter is a tube that carries urine from a kidney to the bladder. Carcinomas arising from these organs create a poor prognosis for survival, if they are not surgically removed before they have metastasized.

In regard to part Ⓐ, the meaning is that the cancer cannot be removed for curative purposes. In other words, all of the cancer cannot be removed, even if surgery were done. If any cancer remains, then part Ⓐ is satisfied.

Part Ⓑ is satisfied if cancer arising from one of the organs mentioned by the listing undergoes distant metastasis through the bloodstream, such as spreading to the brain or liver.

Part Ⓒ is satisfied if cancer arising from one of the organs mentioned by the listing spreads even to the nearest lymph nodes.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match Ⓐ, Ⓑ or Ⓒ, below.

- Ⓐ Unresectable carcinoma.
- Ⓑ Hematogenous spread to distant sites.
- Ⓒ Spread of carcinoma through the lymphatic system to regional lymph nodes or beyond.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and the treatment given. Most kidney cancers arise on one kidney. Even if that one kidney is completely removed the other kidney could function well enough for both—if the remaining kidney is healthy. If not, evaluation would have to be done under the listings for kidney disease in Chapter 21. Similarly, complete removal of one adrenal gland for cancer would probably not result in significant functional

limitations. However, it is possible for cancer to occur in both adrenal glands. If both glands were removed, consideration would have to be given to how well you do with replacement of the hormones lost by removal of the adrenal glands.

25. Listing 13.22: Carcinoma of the Urinary Bladder (Adults)

The urinary bladder stores urine received by a means of a ureter from each kidney. The bladder discharges urine from the body through the urethra. Most urinary bladder cancers are transitional cell carcinomas. Like other cancers, bladder carcinomas have a much better prognosis if detected early, before they have spread beyond the bladder. Even metastasis to regional lymph nodes results in a poorer chance for survival.

Total cystectomy (part ①) means complete removal of the bladder. When cystectomy is necessary, the ureters can be sewed into the last part of the small intestine as a drainage site for urine. Any infections or other complications affecting kidney function as a result of such urinary diversion must be evaluated under Listing 6.02 (Chapter 21), which deals with decreased kidney function (part ②).

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match A, B, C, D or E, below.

- Ⓐ Carcinoma with direct growth through the wall of the bladder.
- Ⓑ Metastasis of carcinoma to regional lymph nodes or beyond.
- Ⓒ Carcinoma that cannot be surgically removed for cure.
- Ⓓ Any recurrence of carcinoma after total cystectomy, in any degree, at any time, anywhere in the body.
- Ⓔ Evaluate kidney impairment after total cystectomy under the criteria in Listing 6.02.

b. Residual Functional Capacity

RFC has little relevance to this listing, since this listing is met when the cancer is advanced enough to cause any significant symptoms or other complications.

26. Listing 13.23: Carcinoma of the Prostate Gland (Adults)

Adenocarcinoma of the prostate gland is a significant killer of men. Early diagnosis is the key to long-term survival. Prostate cancer is common: a large percentage of elderly

men have microscopic cancer in their prostate gland found incidentally at autopsy, but they died of something else first.

Prostate specific antigen (PSA) is a useful test for prostate carcinoma and to monitor recurrence. PSA is measured by a blood test as a possible marker for adenocarcinoma cancer of the prostate gland. Normal levels are 0–4 nanograms/milliliter (ng/ml). PSA cannot be used to diagnose prostate cancer; that can only be done reliably by biopsy. However, values greater than 10 ng/ml should be considered definitely abnormal and the cause investigated. Like other medical tests, appropriate interpretation of PSA requires considerable medical judgment regarding individual patients, especially when there are borderline values in the 4–10 ng/ml range. *Change* in PSA values over time is especially significant. Some noncancerous conditions, such as the commonly occurring enlargement of the prostate known as benign prostatic hypertrophy (BPH), can also raise PSA levels. However, with widespread metastatic prostate cancer involving multiple tumors in bones, a much higher PSA is to be expected than would be seen in noncancerous conditions. The SSA can purchase a PSA test to help in the determination of whether your prostate cancer is controlled, but informed medical judgment is required to interpret the results. Since the listing deals with a question of control by treatment, PSA levels done before and after surgery can be important in deciding that question.

Another important diagnostic tool is high-frequency sound (ultrasound) imaging of the prostate gland through the rectum. The prostate gland lies up against the rectum, so that transrectal ultrasound (TRUS) is a valuable test. TRUS is not sufficient for a definitive diagnosis; only biopsy of the prostate can accomplish that purpose. For TRUS, a transducer probe must be inserted into the rectum. The SSA cannot purchase either TRUS or a biopsy, so if these tests were done, they must be obtainable from your medical records.

Since prostate carcinoma is stimulated to grow by the presence of the male sex hormone testosterone, treatment is directed toward lowering testosterone levels. Suppression of testosterone is accomplished by drugs or by removal of the testes (orchiectomy). Since prostate carcinoma is a hormone-dependent tumor, control may be achieved even if the cancer has metastasized. Prostate cancer frequently spreads to bone. If treatment has just started, the SSA should wait a reasonable amount of time to obtain enough information to make a reasonable judgment about whether the cancer will respond to prescribed therapy. This usually requires waiting at least three months from the beginning of treatment. In fact, treating doctor records are often not very helpful regarding response to treatment until at least six months have passed. Then a much clearer picture can be

obtained. Considerable medical judgment is required to evaluate a claimant's response to prescribed therapy for prostate cancer.

A variety of surgical techniques are available to destroy early, small prostate cancers without radical surgery. Radical prostatectomy carries the risk of impotence.

a. Listing Level Severity

To meet this listing, you must have adenocarcinoma cancer of the prostate gland that is not controlled by prescribed therapy.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and treatment given. Impotence has no relevance to a claimant's ability to work and is therefore not considered on a residual functional capacity (RFC) assessment. Pain from bone lesions and side effects from treatment medication may produce functional limitations.

27. Listing 13.24: Testicular Cancer (Adults)

Choriocarcinoma of the testes (part Ⓐ) is an unusual, but dangerous cancer with a poor prognosis. Choriocarcinoma is known as a type of germ cell tumor. Germ cell tumors are so named because they arise from primitive reproductive cells, which are those of the type that produce eggs (ova) in females or spermatozoa in males. Other possible germ cell testicular cancers include seminomas, embryonal cell carcinomas, teratomas and what are called yolk sac tumors. There are also nongerm cell testicular tumors such as gonadoblastomas, Leydig cell tumors, carcinoid and adenocarcinomas, although they are rare.

All testicular cancers that are not choriocarcinomas, as listed above, are considered under part Ⓑ of the listing, including seminomas. Seminomas are the most common testicular tumor and can often be treated effectively—early stages of the cancer have at least a 95% five-year survival in numerous studies. A majority with more advanced stages of seminoma can be helped with chemotherapy. Removal of the affected testis (orchiectomy) is necessary to eliminate the primary tumor, regardless of its type.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match Ⓐ or Ⓑ, below.

Ⓐ Choriocarcinoma.

Ⓑ Other malignant primary tumors of the testes with progressive disease not controlled with prescribed therapy.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and the treatment given. Choriocarcinoma as described in part Ⓐ of the listing has no relevance to RFC, since the listing is met if it is present in any degree and regardless of any response to treatment. Removal of the testes does not produce work-related functional limitations and would not warrant an RFC. Other malignant tumors in part Ⓑ might involve other organs that would require evaluation under the appropriate listings. For example, spread to the brain would lead to consideration of the neurological listings (Chapter 26) and the mental listings (Chapter 27), as well as any related RFC limitations.

28. Listing 13.25: Carcinoma or Sarcoma of the Uterus (Corpus or Cervix) (Adults)

The corpus is the main body of the uterus. The cervix is the lower portion of the uterus, extending into the vagina. PAP smears are done on the cervix. Uterine cancer may be carcinomas or sarcomas. Squamous cell carcinomas (SCC) are the most common type of uterine cancer and arise from the cervix. Adenocarcinomas arise from the cells lining the inside of the body of the uterus. Sarcomas are much rarer tumors that arise from uterine muscle and exist as a number of specific forms such as leiomyosarcomas and fibrosarcomas.

The prognosis of all uterine cancers is good if the cancer is detected very early. The earliest cervical cancers that are still confined to their cell layer of origin (in situ cancers) may require no more than laser surgery or cryotherapy. Those slightly more advanced but still confined to the cervix may be cured with a simple hysterectomy.

Regardless of the type of uterine cancer, once it has spread through the lymphatic or blood system or has grown outside of the uterus by direct extension, the probability of long-term survival decreases significantly. However, prognosis depends on the specific type of cancer, degree of malignancy of the particular cancer's cells, what other organs are involved and how far the cancer has spread. Surgery, radiation and chemotherapy may all play a role in the treatment of uterine cancer.

Total pelvic exenteration (part Ⓒ) is extremely extensive surgery. It involves removal of pelvic organs—the uterus, ovaries, bladder, rectum and lymph nodes.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match ①, ② or ③, below.

- ① Inoperable carcinoma or sarcoma that is not controlled with prescribed therapy.
- ② Any recurrence of carcinoma or sarcoma after total hysterectomy, in any degree, at any time, anywhere in the body.
- ③ Total pelvic exenteration.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and the treatment given. There are far too many possibilities to consider here. If surgery is confined to removal of the uterus and ovaries, there will be no functional limitation requiring an RFC. Extensive surgery in the form of total pelvic exenteration would constitute an allowance under the listing and so wouldn't need to be considered under an RFC. Radiotherapy given to kill cancer cells may also damage the intestine, resulting in additional pain and nutritional problems. Those cases should be evaluated under the digestive system listings (Chapter 20), as well as the RFC considerations discussed in relation to digestive problems. Other complications can include infection, nerve damage, edema in the legs, incontinence and persistent bladder inflammation (chronic cystitis). These complications are particularly likely to cause chronic pain and limit the amount of time that a person can spend standing and walking.

29. Listing 13.26: Cancer of the Ovaries (Adults)

This listing applies to all cancer of the ovaries, including recurrent cancer. Most ovarian cancers are of the carcinoma type, such as cystadenocarcinomas and undifferentiated carcinomas. There are also many other possible ovarian cancers, such as choriocarcinomas, embryonal cell carcinomas, dysgerminomas and teratomas.

The specific type of ovarian cancer has a lot to do with the prognosis. Choriocarcinomas and malignant teratomas have a particularly poor survival rate. As in other forms of cancer, survival is directly related to how early the cancer can be detected and treated. The chance for long-term survival is much better if the cancer is confined to the ovary and has not metastasized to other organs.

Cystadenocarcinomas may result in a fluid build-up in the abdomen that contains cancerous cells. This condition is called malignant ascites. Once cancer cells are floating

around in the abdomen, they can implant themselves on other organs such as the liver, the peritoneal membrane lining the abdominal cavity or the omentum. The omentum is a sheet of peritoneal membrane between the stomach and other abdominal organs.

a. Listing Level Severity

For your condition to be severe enough to meet the listing, it must match part ①, ②, ③ or ④, below.

- ① Ascites with demonstrated malignant cells.
- ② Growth of the cancer into any body structures (infiltration) outside the ovary, which cannot be surgically removed for cure.
- ③ Spread of cancer by metastasis to the omentum or elsewhere in the abdomen.
- ④ Cancer that has spread too far for surgical removal of the entire cancer for cure (distant metastasis).

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and the treatment given. When radiation treatment is necessary, the most common complication is damage to the intestine, a condition known as radiation enteritis. In over three-quarters of patients treated with high-dose radiation, there will be nausea, vomiting, diarrhea and weight loss. In most of these cases, symptoms improve within several weeks after treatment. But nearly 30% may have persistent diarrhea and about half this number will have intestinal narrowing and bleeding that requires surgery. The kidney and liver can also be damaged by radiation. Claimants receiving radiation therapy would probably meet the listing without the need to consider the complications of radiation. But after three years with no evidence of cancer, a claimant would no longer meet the listing and could still be suffering complications from treatment that would require an RFC.

30. Listing 13.27: Leukemia (Adults)

Leukemia is evaluated under the blood disorder listings (that begin with the number 7 in Chapter 22.) Specifically, the adult listings dealing with leukemia are 7.11 (acute leukemia) and 7.12 (chronic leukemia).

a. Listing Level Severity

To evaluate severity, look under the appropriate listings dealing with blood disorders (in Chapter 22.)

b. Residual Functional Capacity

See the discussion of RFC under the listings dealing with leukemia in Chapter 22.

31. Listing 13.28: Carcinoma or Sarcoma of the Uterine (Fallopian) Tubes (Adults)

The right and left fallopian tubes carry eggs from the ovaries to the uterus. Like any other living tissue, the fallopian tubes can give rise to cancer. Fallopian tube cancers can be carcinomas or sarcomas. These cancers can be cured if the cancer is carcinoma in situ (Stage 0). Surgery would then remove all of the cancer. Unfortunately, as with other cancers, in situ cancer is not likely to produce symptoms, and so detection at that stage only occurs incidentally to investigation of some other medical problem.

Even carcinomas apparently confined to the fallopian tube at diagnosis (Stage I) result in only about a 60% five-year survival rate. The reason for this is probably that cancerous cells leak from the fallopian tube into the abdominal cavity, where they can implant on the peritoneal membrane lining the abdominal cavity or other organs such as the liver or outer surfaces of the intestines. The most advanced disease spreads outside of the abdomen and these patients have little chance for survival for an extended period of time. Most fallopian tube cancers are carcinomas and they make up only a smaller percentage of cancers arising in the female reproductive organs. Sarcomas of the fallopian tubes are extremely rare cancers.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, it must match **A** or **B**, below.

- A** Cancer that cannot be surgically removed for cure.
- B** Metastasis to regional lymph nodes or beyond.

b. Residual Functional Capacity

Like ovarian cancer, radiation therapy to the abdomen may be needed and you may have similar complications. See the discussion of RFC under Listing 13.26.

32. Listing 13.29: Carcinoma of the Penis (Adults)

The great majority of penis cancers are squamous cell carcinomas (SCC) and are rare malignancies in the United States. Other less common penile cancers include melanomas, basal cell carcinomas and Kaposi's sarcoma, as well as involvement of the penis with lymphoma or infiltrates of leu-

kemic cells. However, this listing specifically refers to carcinoma only. In countries where personal hygiene is poor and circumcision uncommon, penile carcinoma accounts for a much higher percentage of male cancers. Most penile cancer occurs in men over age 50. Because these cancers are painless, many men delay going to a doctor for over a year after a visible cancer appears.

Treatment with radiation may be highly effective for localized cancers. The advantage of radiation is that it can leave the penis more functional. Advanced cancers, or those in which radiation has failed, require surgical control with partial or total removal of the penis. Chemotherapy has been of benefit in some cases with inoperable cancer of the penis.

The inguinal lymph nodes in the groin, the area of the crease where the thigh meets the abdomen, are the regional lymph nodes of concern. Cancer in these nodes and especially metastasis beyond the inguinal nodes decreases survivability.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have carcinoma of the penis with metastases to the regional lymph nodes or beyond.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and the treatment given. However, penile carcinoma meets the listing if it even spreads to the nearby lymph nodes, so if it doesn't meet the listing it is unlikely to be associated with a significant work-related impairment that would require an RFC.

33. Listing 13.30: Carcinoma of the Vulva (Adults)

The vulva are the external female genitalia. Vulvar carcinoma is uncommon, making up only about 3–4% of female genital cancers. Most cancers of the vulva are squamous cell carcinomas (SCC), accounting for about 90% of cases. If the cancer is so early that it is in situ cancer, a complete cure can be achieved by a wide excision around the cancer with skin grafting. Other treatments for in situ carcinoma include lasers, cryosurgery and topical drugs. In situ cancer is Stage 0.

Vulvar carcinomas of Stage I or more require radical surgical removal of the vulva. The majority of patients with Stage I vulvar carcinoma will survive five years, while most with advanced (Stage IV) cancers will be dead within five years.

The inguinal lymph nodes in the groin, the area of the crease where the thigh meets the abdomen, are the regional lymph nodes of concern. Spread of cancer beyond these nodes is considered distant metastasis.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have carcinoma of the vulva with cancer that has spread too far for surgical removal of the entire cancer for cure (distant metastasis).

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the cancer and treatment given. In cancers that don't meet the listing, there may be pain associated with radiation or drug treatment applied directly to the cancer. Systemic chemotherapy is not often given for vulvar carcinoma. Because of the variations in radiation treatment given by different doctors, it is difficult to predict individual side effects to treatment. Barring unforeseen complications, it is quite possible for there to be no significant limitations following recovery from treatment. ■

Chapter 29

Immune System Disorders

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Definitions

The following definitions are for words used in this chapter and during the SSA disability process. If you need additional definitions, consult a good medical dictionary, available in most bookstores and libraries. You can also look at online medical dictionaries like the one at www.nlm.nih.gov/medlineplus.

Abscess. An infection occurring as a localized collection of pus.

Anemia. Low red blood cell count usually determined by a decrease in the hematocrit.

Angiography. Any technique to produce images of arteries, such as by x-ray or MRI scan. Usually involves injection of contrast material into the artery to make it visible. Also known as *arteriography*.

Ankylosing spondylitis. Inflammatory disease of the spine and its supporting ligaments, as well as of the sacroiliac joints and sometimes other parts of the body.

Ankylosis. When a joint or spine is fixed so that it can't move. Ankylosis may be caused by arthritis that fuses joint bones together. For example, an arthritic bone spur may grow across the space of the knee joint so that the joint cannot move. Ankylosis can also be caused by soft tissue damage around a joint, such as scarring of skin and inflamed fibrosis of ligaments and tendons.

Anorexia. Loss of appetite. Anorexia is a frequent problem in chronic diseases, including cancer.

Anterior and lateral ligaments. Ligaments that run up and down the outside of the spine, helping hold the vertebrae in place.

Anterior neck flexors. Muscles that move the head forward in a standing position or upward in a lying (supine) position.

Antibodies. See *immunoglobulins*.

Antigens. Substances that trigger the body's immune system. Antigens are usually foreign substances such as allergens, bacteria or viruses, but there are also *autoimmune disorders* in which the immune system mistakenly reacts to its own tissues as if they were antigens.

Antinuclear antibodies (ANA). Abnormal antibodies are found in the bodily fluids of many patients with autoimmune diseases, such as systemic lupus. ANA results are reported by laboratories in degrees of abnormality called titers. A higher titer reading suggests a more severe disease. Although it is possible for positive ANA results to occur in normal people, they would be in the low titer ranges of 1:20 to 1:40, which are generally interpreted as negative results.

Anus. Terminal opening of the gastrointestinal tract, through which feces exits the body.

Apophyseal articulations. Parts of the upper and lower surfaces of vertebrae that attach to the intervertebral discs and anterior and lateral ligaments and run up and down the outside of the spine.

Arteritis. Inflammation of an artery.

Arthralgia. Joint pain. Not the same as arthritis, which is disease affecting a joint. Arthralgia usually accompanies arthritis.

Arthropathy. Joint disease.

Aspiration. Getting food or other foreign materials into the trachea or lungs, as caused by defects in the swallowing mechanism.

Atrophy. To get smaller.

Autoimmune disorders. Disorders in which a person's immune system forms antibodies against their own tissues.

Bacteremia. The presence of bacteria in the blood.

Bacteria. Microscopic plants consisting of a single cell.

Behcet's syndrome. A potentially life-threatening immune disorder that causes painful ulcerations of mucous membranes, such as the mouth and genitalia. Multiple other body systems can also be involved with the inflammation, such as the eye (uveitis), joints (arthritis), colon (colitis), and central nervous system (encephalopathy).

Biopsy. The process of taking a sample of tissue for detailed analysis of various kinds. Biopsy specimens are observed grossly with the eyes, microscopically with a variety of possible tissue stains, and in some cases may undergo specific chemical and DNA analysis.

Bronchi. Larger airways branching from the trachea to the lungs.

Bronchial washings. Samples of fluid created by putting small amounts of salt solution (saline) into a bronchus and then sucking it back out. The saline washes over a suspected abnormal area that may contain cancerous cells, bacteria, fungi or other evidence of abnormality. The saline contains salt (NaCl) at normal body concentration so that it does not irritate tissues or damage any material it picks up.

Bronchitis. Inflammation of bronchial airways; may be associated with infection or other sources of irritation such as allergy, smoke or chemical fumes.

Calcinosis. Abnormal calcium deposits in tissues.

Candidiasis. A common type of fungal infection, frequently referred to as a "yeast infection."

Cardiac arrhythmia. Abnormality in the rate or rhythm of the heart beat.

Cardiomyopathy. Any disease of heart muscle. Many things can cause cardiomyopathies including ischemia, viruses, drugs, alcohol and autoimmune disorders like systemic lupus erythematosus (SLE).

Cell-mediated immunity. Immune system functions carried out by cells, particularly white cells known as T lymphocytes.

Cervical lymph nodes. Lymph nodes in the neck.

Cervical spine. Spine in the neck.

Cervix. The lower part of the uterus, extending into the vagina. PAP smears are done on the cervix.

Definitions (continued)

Chorioretinitis. Inflammation of the choroid and retina of the eye. The choroid is a vascular layer in the wall of the eye that supplies blood to the retina, and carries nerves and blood to the front parts of the eye.

Chronic. Persistent.

Clinical abnormalities. Physical or mental abnormalities that can be directly observed in a patient, in contrast to the study of laboratory abnormalities such as blood tests, x-rays, etc.

Complement. Any of a group of about 30 substances, usually protein enzymes, that can be found in the blood or on the surfaces of cells. Complement reactions are complex. Basically, complement assists in producing an inflammatory response to infections and in destroying viruses and bacteria. Complement can also play a role in immune system disorders.

Computerized axial tomography scan (CAT scan, CT scan). X-rays taken under computer guidance, consisting of many picture slices of high resolution. They show much greater detail than plain x-rays.

Congenital. Dating from the time of birth. Congenital disorders may result from abnormal genes or some abnormality in the intrauterine environment before birth.

Constitutional. Affecting the whole body; not local.

Contracture. When a limb strongly resists movement from a fixed abnormal position as a result of fibrosis or scarring of ligaments, tendons, muscles or other soft tissues around joints. Contractures of limbs in a bent position are the most common and are known as “flexion contractures.”

Corticosteroids. Drugs that have the same action as the natural steroid hormone cortisol. Corticosteroids help combat many diseases, but their side effects can be serious if taken for a long time. Chronic use of steroids also indicates the severity of the disease being treated.

Cricopharyngeal muscles. Muscles deep in the neck and just above the beginning of the esophagus; weakness of these muscles could result in dysphagia.

Cryoglobulinemia. Cryoglobulins in the blood. Cryoglobulins are abnormal immunoglobulins (antibodies) that become insoluble in blood when exposed to slightly lower than normal temperatures. Certain areas of the body are particularly susceptible to cold—the fingertips, earlobes, tip of the nose, the toes and the cheeks. With exposure to cold, cryoglobulins may gel in the blood stream, so that blood flow slows with resultant symptoms and physical abnormalities in the area affected. Symptoms disappear with warming of the body part so that the abnormal immunoglobulin dissolves again in the blood.

Culture. Growing of bacteria, viruses, fungi or cells on an appropriate nutrient medium. Cultures are important in diagnosing the cause of an infection, and in determining the drug sensitivity of various microscopic organisms so that the correct drug can be administered.

Cytology. The study of cells. Cytologic tests may involve various kinds of staining of cells to reveal abnormalities such as cancer, or the extraction of DNA or other cellular materials for study.

Diaphragm. The right and left dome-shaped sheets of muscle that separate the chest and abdominal cavities. Movement of the diaphragm changes the air pressure inside the chest, thereby helping air movement in breathing. When the diaphragms move down, the space inside the chest gets larger and the resulting drop in pressure inside the chest causes air to move into the lungs through the mouth or nose. When the diaphragms move back up, the pressure inside the chest increases and air moves out of the lungs through the mouth or nose.

Digital. Reference to the fingers.

Dilation. Widening.

Dorsolumbar spine. Spine area in the lower part of the chest and upper part of the lower back.

Dysmotility. Abnormal movement, such as abnormal contractions in the muscles of the esophagus.

Dysphagia. Difficulty swallowing.

Eczema. General word for a type of itchy skin inflammation. Erythema develops in the area of skin involved as a result of inflammation, followed by oozing of clear fluid that tends to produce crusting. Small blisters are present (vesiculation), and there may also be scaling and thickening of the skin in advanced cases.

Effusion (of joint). Abnormal collection of fluid in a joint space.

Electromyogram (EMG). Recording of a muscle’s electrical response to electrical stimulation. The size (amplitude), number (frequency) and shape of the electrical outputs from stimulated muscles provide important information that can be related to both nerve diseases and muscle diseases.

Encephalopathy. Any physical abnormality of the brain that produces mental abnormalities, especially when the brain as a whole is affected. Encephalopathy may be reversible or irreversible, depending on the cause.

Erosion of bone. Areas of bone loss due to a disease process.

Erythema. Redness of the skin caused by increased blood flow in the small capillary blood vessels. Erythema often accompanies inflammation, because inflammation is associated with the release of substances that dilate blood vessels and increase blood flow.

Erythrocyte sedimentation rate (ESR). Test that measures how quickly red blood cells settle; the faster the settling, the more abnormal the result. An elevated ESR indicates some type of inflammation somewhere in the body; it does not diagnose one particular disease. A normal ESR is about 10 mm/hr or less in men and 20 mm/hr or less in women, depending on the method used by the reporting laboratory.

Esophageal dysmotility. Abnormal contractions of muscles in the esophagus. Esophageal dysmotility is associated with

Definitions (continued)

fibrosis of the esophagus, which can lead to narrowing of the esophagus with difficulty eating and maintaining adequate nutrition. Pain may also accompany esophageal contractions.

Esophagitis. Inflammation of the esophagus. The most common cause of esophagitis is gastroesophageal reflux.

Extra-articular. Any location outside of the joints, as in the lung, eye or heart.

Facet joints. Small joints between vertebrae.

Failure to thrive. A condition in which infants fail to gain weight at a normally expected rate, or they lose weight. Failure to thrive is often caused by nonphysical factors associated with parental care of the infant. However, it may also result from any type of severe physical disease.

Fibrosis. Degenerative process involving the replacement of normal tissue with fiber-like tissue.

FIGO. International Federation of Gynecology and Obstetrics.

Fine movements. Coordinated manipulation with the fingers, such as picking up coins, buttoning a shirt, typing, playing the piano or handling anything with the fingertips.

Fungating. Lesions that appear as fungus-like growths. Fungating is a descriptive term about the appearance of an abnormality—bulky and fungus-like—and does not necessarily imply the presence of a fungal infection.

Fusion. See *ankylosis*.

Gangrene. The death of soft tissues, associated with a loss of blood supply and possibly followed by bacterial infection. If there is no bacterial infection, the gangrene is said to be dry gangrene.

Giant cell arteritis. A type of vasculitis that can affect any artery. For example, inflammation of head arteries (such as the temporal artery) can result in headache. Decreased blood flow to the optic nerve can impair vision.

Gross movements. Grasping and holding onto fairly large objects with the hand as a whole, such as turning a door knob, lifting a pan or handling a wrench.

Helminth. A type of parasitic worm.

Helper/suppressor ratio. The number of helper lymphocytes (CD4 lymphocytes) divided by the number of suppressor lymphocytes (CD8 lymphocytes). An abnormally low CD4/CD8 ratio suggests that CD4 lymphocytes are being destroyed, such as would be expected with aggressive human immunodeficiency virus (HIV) infection.

Hepatitis. Inflammation of the liver. A common cause of hepatitis is alcohol abuse. A number of viruses (known by letters; for example, A, B, C, D and E) can cause hepatitis, as can toxins and drugs.

Hilar lymph nodes. Nodes situated in the hilum of each lung, a location where arteries, veins and lymphatic vessels enter the right or left lung.

Histological tests. Tests performed on pieces of biopsied tissue.

Histology. The study of tissues. Tissues are groups of cells with a specialized function.

Humoral immunity. Immune system functions carried out by antibodies. Antibodies are produced by B lymphocytes.

Hypoplasia. Underdevelopment of an organ or other bodily structure.

Immunoglobulins (Ig). Chemicals produced by plasma cells that are part of the body's immune response to antigens. Immunoglobulins perform many specialized functions. The various types of immunoglobulins are G, M, A, D and E. These are abbreviated as IgG, IgM, IgA, IgD and IgE. Also known as *antibodies*.

Immunologic. Reference to the immune system.

Inflammation of joints or other tissues. Redness, swelling, pain, warmth and tenderness. Because skin tones vary, a lack of redness doesn't rule out inflammation if the other findings are present.

Intercostal muscles. The muscles between the ribs, important in controlling the size of the chest in breathing movements.

Iridocyclitis. Inflammation of the eye's iris and ciliary body.

Ischemic ulcers. Areas of dead tissue resulting from poor blood supply. In autoimmune disorders, ischemic ulcers may develop in the fingertips and toes as a result of vasospasm.

Lesion. Abnormality.

Leukopenia. Decreased white cell count in blood.

Leukoplakia. White patches in the mouth that cannot be rubbed off. The patches are caused by abnormal skin cells and represent a precancerous condition. A common cause of leukoplakia is chewing tobacco and is a danger signal requiring medical evaluation. A particular type of leukoplakia, oral hairy leukoplakia, may indicate impending AIDS. Leukoplakia should not be confused with white patches caused by candida fungal infection that may occur on the tongue or elsewhere in the mouth.

Ligaments. Flat, flexible, tough connective tissue that extends between bones and across joints to hold bones in position.

Lordosis. Curvature of the spine normally present to a moderate degree in the lumbar spine and to a mild degree in the cervical spine. The spine looks as if a flexible straight rod had been pushed forward from behind while the bottom remained in place. The lay term is swayback.

Loss of motion (LOM). See *range of motion*.

Lumbar spine. Spine area in the lower back.

Lymph nodes. Specialized collections of cells found in various locations along the system of lymph vessels. Lymph nodes function for the immune system and contain lymphocytes. For example, lymph nodes can trap and destroy bacteria. Lymph nodes also may contain cancerous cells that are being spread through the lymphatic system. Therefore, biopsy of lymph nodes is important in determining whether cancer has metastasized from the original tumor.

Definitions (continued)

Lymphomas. Cancers of the lymph nodes and spleen that result in abnormal lymphocytes. Lymphoma can invade any organ of the body. *Hodgkin's lymphoma* and *Non-Hodgkin's lymphoma* are two important classifications.

Magnetic Resonance Imaging (MRI). A method of producing pictures of internal body structures using magnetic fields and radiofrequency fields. MRIs do not utilize x-rays or other radiation.

Malaise. A general feeling of body discomfort and tiredness.

Meninges. Membranes covering the brain and spinal cord. The thickest, outer meningeal membrane is called the *dura mater* which surgical or other medical reports usually just call the "dura."

Meningitis. Inflammation of the meninges. The word is also used in association with a particular kind of infection of the meninges. For example, *cryptococcal meningitis* is infection of the meninges with the *cryptococcus* fungus, *viral meningitis* means infection with a virus.

Microcephaly. An abnormally small head.

Morphea. A localized form of *scleroderma*. At first the morphea skin patches may be soft with a violet tint, but over time become harder and attain a yellowish or ivory color. The local lesions of morphea may spread out over the body to produce a more generalized involvement of the skin.

Motility. Motility means movement and is especially used in reference to the esophagus, stomach and intestines. These organs have specific normal patterns of motility based on contractions of the muscles within them.

Mucocutaneous. Reference to the skin and mucous membranes.

Mucous membranes. The moist membranes covering the inner surfaces of the lips, the inside of the mouth and the inner surfaces of the female genitals (vulva).

Mycobacterial infections. *Mycobacteria* are a group of bacteria, including the species causing *tuberculosis* (TB). Atypical *mycobacteria* (for example, *M. kansasii*, *M. intracellulare*) are nontuberculosis-type bacteria that may also cause infection.

Mycotic infections. Infections caused by fungi.

Myositis. *Myositis* means inflammation of muscle. *Polymyositis* is a disorder characterized by widespread inflammation of muscle.

Nephropathy. Kidney disease.

Neuropathy. Any disease of peripheral nerves. Peripheral nerves are those connecting the spinal cord to the various organs and tissues of the body. Kidney failure is one possible cause of neuropathy. Neuropathy is best demonstrated by weakness, decreased reflexes, loss of sensation and decreased nerve conduction velocity (NCV).

Neurosyphilis. Syphilis of the nervous system, particularly infection of the spinal cord and brain.

Opportunistic diseases. Diseases that arise as a result of a weakened immune system, caused by diseases such as AIDS.

Oral hairy leukoplakia. Leukoplakia refers to white patches on one or both sides of the tongue. The leukoplakia may also have a hairy appearance because old skin cells fail to fall off and instead become fine filaments that look like hairs. About 75% of HIV patients with oral hairy leukoplakia later develop AIDS. However, any person with severe suppression of their immune system—such as transplant patients receiving potent immune-suppressing drugs—can develop oral hairy leukoplakia. The leukoplakia itself often produces no symptoms.

Otitis media. Middle ear infection.

Parasite. A plant or animal that lives off another plant or animal. Parasites can be microscopic or as large as a worm.

Pelvic inflammatory disease (PID). Infection involving the female reproductive organs: the ovaries, fallopian tubes or uterus.

Percentile. Method of comparing something, like height or weight, to normal expected values, in order to decide the probability that it is normal or abnormal. For example, a person with a weight in the 60th percentile is heavier than 60% of other people and lighter than 40% of other people.

Perianal. Near the anus.

Pericardium. The thin, moist, membrane that surrounds the heart.

Peripheral joints. Refers to joints of the limbs, in contrast to those of the spine.

Pneumonitis. Inflammation of lung tissue, whether from infection or inhalation of irritating substances like smoke, dust or chemical fumes.

Polyarteritis nodosa. Immune disorder of unknown cause producing widespread arterial inflammation. Any organ in the body can potentially be damaged, depending on the location of the arteritis: most commonly involved are arteries to the kidney, liver, gastrointestinal tract and heart. If arteries supplying the brain are involved, headaches or even seizures can occur. This disorder progresses slowly in some cases, while in others it is fatal within months. It is most common in middle-aged men. The most frequent symptoms are arthralgia, weakness and abdominal pain. High blood pressure may be present. Most patients die within a year without treatment from causes like heart failure, bleeding, ruptured aneurysms, kidney failure or gastrointestinal bleeding. Even with treatment the five-year survival rate is generally poor. Also known as *polyarteritis*, *periarteritis* and *periarteritis nodosa*.

Prognosis. The likelihood of recovery from a disorder.

Protozoans. Microscopic, single-celled animals. Some cause disease in humans.

Psoriasis. A chronic hereditary skin disorder usually characterized by white—sometimes pinkish—scaly, raised and flat

Definitions (continued)

lesions. Any part of the skin surface may be involved, but lesions are most common on the elbows and knees.

Range of motion (ROM). How well a joint moves. ROM is extremely important in determining how limiting arthritis is likely to be. For example, a knee joint that has only a small degree of motion will limit the ability to walk and otherwise use the legs much more than a knee joint with a normal or mildly restricted range of motion. A person's ROM may be limited not only by arthritis, but also by loss of flexibility in the soft tissues around the joints. ROM is usually reported in degrees of flexion (bending of a limb or the spine) and extension (straightening a limb), abduction (movement of a limb away from the body in a right or left direction), adduction (movement of a limb toward the body from a right or left position), rotation, etc., depending on the joint involved.

For Social Security disability purposes, all ROM measurements must be passive—meaning measured when you relax and let a doctor move the joint for you. The only exception is the spine, for which you must actively participate in movements. Active range of motion is where you voluntarily move a joint. Measurements of active ROM are considered unreliable because they depend on the applicants to honestly move their joints to the maximum degree when asked. Active ROM tests can lead to serious disagreements between you and the SSA. If you state that you cannot bend, but physical tests or x-rays do not verify your claim, the SSA does not have to believe you. SSA evaluations frequently reveal (through physical examinations, x-rays and other laboratory tests) that applicants alleging incapacitating arthritis and inability to move joints actually have a good ROM and minimal abnormalities.

Raynaud's phenomenon (disease). Raynaud's phenomenon is a disorder characterized by episodes of arterial vasospasm, especially involving the fingers or toes. Raynaud's phenomenon may exist alone and be fairly harmless. However, it is frequently associated with some immune system disorders. When it is, it is referred to as Raynaud's *disorder*, although some doctors do not make this distinction. Raynaud's phenomenon is usually triggered by cold or emotion. There is a pattern of pale color to the area affected, because blood flow decreases. Then a bluish or purplish coloration appears. As the episode ends and blood flow is restored, the part affected becomes redder.

Reiter's syndrome. An immune system disease classically involving inflammation of the urethra (urethritis), eye (conjunctivitis) and joints (arthritis). However, this classic triad of findings is present in only a minority of people with the disorder. Multiple other organ systems, such as the heart and nervous system, can also be involved. This syndrome is most common in men in the 20 to 40 age range.

Retrovirus. Any virus of the family Retroviridae, such as the human immunodeficiency virus (HIV) that causes AIDS. Retroviruses have a single-stranded ribonucleic acid (RNA) core, but use an enzyme called reverse transcriptase to produce a DNA (deoxyribonucleic acid) copy of their RNA. This viral DNA then integrates itself into the DNA of the host cell that the virus has infected. In the case of the AIDS virus, invasion of host T4 (CD4) lymphocytes leads to cell death with resulting immune deficiency.

Rheumatoid arthritis (RA). A disease of the immune system, particularly associated with swelling, redness and tenderness of the joints. The small joints of the hands are most susceptible, but any joint in the body can be affected. If not treated adequately, RA can result in extensive bone destruction and deformity. Although best known as a cause of severe arthritis, RA has numerous other potentially harmful effects on the body that can involve the lungs, spleen, heart, pericardium, blood vessels, nerves or eyes, and it can even produce anemia.

Rheumatoid factor (RF). Certain abnormal antibodies that the body has produced and that are especially associated with rheumatoid arthritis. However, it is possible to have rheumatoid arthritis without testing positive for RF. At the same time, you may test positive even if you don't have arthritis. RF is reported by laboratories as "positive" or "negative," and also as degrees of abnormality called titers. For example, higher titers, such as 1:500 versus 1:50, suggest more severe disease activity.

Sacroiliac joints. Joints between the pelvic bones and the sacrum of the spine.

Sacroiliitis. Inflammation of a sacroiliac joint.

Sclerodactyly. Scleroderma affecting the fingers. Hard, thickened skin may make use of the fingers difficult.

Scleroderma. The fibrotic hardening and thickening of skin caused by the autoimmune disorder that causes progressive systemic sclerosis (PSS). The presence of scleroderma doesn't necessarily mean there is full-blown PSS. However, some doctors use the word "scleroderma" to mean "progressive systemic sclerosis," and this fact should be taken into account when an examiner is considering a claimant's diagnosis.

Sepsis. Severe illness resulting from an infection in tissues or the blood with disease-causing microorganisms, particularly bacteria or fungi. Sepsis can result from the microorganisms themselves or from toxins they produce. *Septicemia* specifically means sepsis involving the blood. However, note that infection of a joint known as *septic arthritis* is not usually associated with sepsis; the effect of the infection may be confined to the joint space.

Serological tests. Blood tests related to immune processes, such as levels of antibodies and antigens in the blood. Serological tests are important in establishing prior infection as well as monitoring ongoing infection in some diseases. Serological tests can apply to bacterial, viral, fungal or protozoan infections.

Definitions (continued)

Sjogren's syndrome. A disorder characterized by decreased tear and/or saliva production. Decreased tear production results in a drying of the eyes, a condition known as keratoconjunctivitis sicca. The whole complex of abnormalities (such as tooth decay and damage to the tongue) associated with decreased saliva production is called xerostomia. Ninety percent of cases are women. Sjogren's syndrome can be caused by connective tissue diseases, cancers, liver disease, inflammation of the spine (spondylitis) and others.

Spine. Bony vertebrae stacked on top of each other and separated by intervertebral discs that permit some degree of cushioning and flexibility. The seven vertebrae of the neck (C1-C7) are called the cervical spine. The 12 vertebrae in the chest are the thoracic spine (T1-T12), while the five vertebrae in the lower back are known as the lumbar spine (L1-L5). Beneath the lumbar spine is the sacrum, which consists of a triangular piece of bone of sacral vertebrae fused together (S1-S4). At the end of the spinal column is the tailbone (coccyx). The vertebrae forming the spine are overlaid and connected by many spinal muscles and ligaments. They also form small joints between each other called facet joints.

Spondyloarthropathy. A group of disorders involving the joints of the spine. If the arthropathy also involves an inflammatory process, the resulting disorder is a type of inflammatory spondyloarthropathy.

Spondylitis. Inflammation of the spine. The term does not necessarily signify arthropathy.

Subcutaneous nodules. Lumpy abnormalities of tissues beneath the skin that are sometimes associated with rheumatoid arthritis.

Syndrome. A set of signs and symptoms that occur together.

Synovial membranes. Membranes that surround and help lubricate joints; they become inflamed and tender in active rheumatoid arthritis.

Systemic. Affecting the body as a whole.

Takayasu's arteritis (aortic arch syndrome). Vasculitis of unknown cause involving the aorta and some of its major branches. Joint inflammation and pain early in the disease are eventually followed by decreased blood flow to organs and limbs. For example, decreased blood flow to the brain can impair thinking, while poor blood flow to the limbs can cause tissue damage such as ulcerations of the fingers or toes.

Telangiectasia. Lesions characterized by an area of permanent dilation of blood vessels in the skin or mucous membranes. These lesions can be seen with the unaided eye.

Thrombocytopenia. Decreased platelets in blood.

Ulna. Small bone in the forearm between the elbow and wrist, on the same side of the forearm as the little finger.

Ulnar deviation. Deformities of the fingers that severely limit use of the hands, usually found in rheumatoid arthritis. This condition typically results in a sideways pointing of the fingers.

Undifferentiated. Lacking specialization, as when a connective tissue disorder has features of multiple specific disorders.

Valgus. Reference to a deformity in which a body part is bent outward from the midline of the body.

Varus. Reference to a deformity in which a body part is bent inward toward the midline of the body.

Vascular. Reference to blood vessels.

Vasculitis. Vasculitis means inflammation of a blood vessel, which could be an artery or vein. However, the word vasculitis is usually used in reference to arterial inflammation. *Systemic vasculitis* is more serious, since many arteries are involved. *Arteritis* specifically refers to arterial inflammation.

Vasospasm. An abnormal contraction of muscles in the walls of arteries affected, causing those vessels to narrow. Such vasospasm decreases the ability of the artery to provide blood to the tissues it serves.

Viral inclusion bodies. Microscopic clumps of material in cells associated with some types of viral infection, such as cytomegalovirus.

Vulva. The external female genitalia.

Vulvovaginal. Reference the external female genitalia and vagina.

Wegener's granulomatosis. A form of arteritis causing damage to the respiratory system (nose, sinuses and lungs), as well as the kidneys and heart. However, any organ system can be involved. This is a serious disorder with numerous possible serious effects, including neurological involvement. Arthralgias may be present. The mortality untreated is extremely high. Although about 90% of cases will improve with initial treatment, a third of cases will relapse and about 20% will ultimately die.

Whipple's disease. An immune disorder that predominantly affects males and may involve numerous body systems. The effects of this disorder may include abdominal pain, arthritis, malabsorption of nutrients from the intestine, nervous system abnormalities, anemia and skin, lung or heart disease.

Zygoma. Cheekbone.

A. General Information

While most systems in the human body consist of bones, muscles, veins, arteries and organs, the immune system is made of different types of cells that protect the body from disease.

1. Parts of the Immune System

The disorders listed by the SSA as making a person eligible for disability benefits include deficiencies of one or more parts of the immune system, including:

- antibody-producing B lymphocyte cells
- various types of cells associated with cell-mediated immunity including T lymphocyte cells
- white cells known as macrophages and monocytes, and
- components of the complement system.

2. Dysfunction of the Immune System

Two types of immune system dysfunction that are important to understand are connective tissue disorder (Subsection a, below) and HIV (Subsection b, below).

a. Connective Tissue Disorder

Abnormal function of the immune system may result in the development of a connective tissue disorder. Connective tissue disorders include several chronic disorders affecting multiple organs. These various connective disorders differ in their clinical manifestation, course of illness and outcome. They generally evolve and persist for months or years, may result in loss of functional abilities and may require long-term and repeated evaluation and treatment.

The documentation needed to establish the existence of a connective tissue disorder is medical history, physical examination, selected laboratory studies, medically acceptable imaging techniques and, in some instances, tissue biopsy. However, the Social Security Administration will not purchase diagnostic tests or procedures that involve significant risk, such as biopsies or angiograms. Generally, the existing medical evidence will contain this information.

A medical record covering a continuous period of at least three months is necessary for assessment of the severity and duration of an impairment. This medical record must be “clinical,” meaning involving actual visits to a treating doctor for examination. The records should also show active disease despite prescribed treatment during this three-month period with the expectation that the disease will remain active for 12 months.

To permit the accurate application of a listing, specific diagnostic findings should be documented in the clinical record for each of the connective tissue disorders. These diagnostic findings must be present for systemic lupus erythematosus (SLE), systemic vasculitis, systemic sclerosis and scleroderma, polymyositis or dermatomyositis and undifferentiated connective tissue disorders. See the comments under each listing for a discussion of the required diagnostic findings.

In addition to the limitations caused by a connective tissue disorder, itself, any harmful side effects of treatment must be considered. For example, long-term use of corticosteroids such as prednisone may result in the deterioration of bones, which, in turn, can result in functional loss.

Connective tissue disorders may prevent performance of any gainful work activity because of severe loss of function in a single organ or body system or lesser degrees of functional loss in two or more organs or body systems. Such functional loss may also result from fatigue, fever, malaise and weight loss.

The SSA uses the term “severe” in connective disorder listings to describe medical severity in the common meaning of the word. The word “severe” does not have the same meaning as it does in some other federal regulations used by the SSA, where it simply means more than slight or mild.

Allergic disorders, such as asthma or allergic skin disorders like atopic dermatitis, are discussed and evaluated under the appropriate listing of the affected body system, such as those listings dealing with skin disorders (Chapter 23).

b. Human Immunodeficiency Virus (HIV) Infection

Infections with the human immunodeficiency virus (HIV) continue as a worldwide problem. HIV started in Africa, and was acquired by humans in the form of a mutated simian immunodeficiency virus (SIV) from monkeys or apes. In other words, there was somehow a cross-species transmission of the virus. Although the original infection was concentrated in the male homosexual population, HIV infection is now a serious risk of unprotected sexual intercourse in all groups of people regardless of their sexual orientation. Transmission occurs through microscopic abrasions on contact surfaces during sexual intercourse.

HIV infection can also take place through blood transfusions or any other open place where infected blood can enter the body. Medical personnel have been infected by exposure to HIV-infected blood through small cuts or damaged skin where the virus could enter. An accidental needle stick with a syringe used to draw HIV-infected blood is very dangerous because it injects virus into the tissues where it can enter the bloodstream. People receive-

ing blood transfusions are at small risk, because the blood supplies in the United States are carefully checked for HIV infection. However, it is important that authorities keep up with detection of new HIV strains that may appear (see below). Other viruses, like hepatitis, can also be transmitted by accidental needle sticks. In general, it is a good idea to treat all exposure to blood as very dangerous, even from people who are thought to be healthy. Babies can be infected with HIV from their mothers by breast-feeding.

Although HIV infection may lead to AIDS, it is not, by itself, the same as having the acquired immunodeficiency syndrome (AIDS). Infections with HIV may produce no symptoms, and there are thought to be several million people in the United States who do not know they are infected. They are, however, capable of infecting others. Claimants with no significant symptoms or other abnormalities other than HIV infection are not considered disabled by the SSA, since they have no functional restrictions that would prevent work. This is an important point, because claimants with HIV infection alone frequently apply for disability benefits and erroneously allege that they have AIDS.

The SSA should allow all cases of accurately diagnosed AIDS; some cases of HIV infection without AIDS are allowable if their condition is severe enough, even though they don't officially qualify for a diagnosis of AIDS. This is because it is the claimant's medical condition, rather than a diagnosis, that is evaluated by the SSA. See Listing 14.08 and accompanying comments.

The human immunodeficiency virus damages the immune system by destroying CD4 (T4) lymphocytes. When HIV infection damages the immune system enough, there is risk of developing various cancers, as well as parasitic, viral, bacterial, fungal and protozoan infections. Additional infections resulting from HIV infection are known as opportunistic infections, because it is the "opportunity" provided by a weakened immune system that allows them to do their damage. When these severe additional infections or cancer appear in people with HIV infection, AIDS is then the proper diagnosis and marked functional limitations may be present. Weight loss and malnutrition that may also be a problem in AIDS, is known as wasting syndrome. Sexually transmitted diseases (STDs), such as syphilis and gonorrhea, are also much more common in people with HIV infection and can cause additional difficulties that must be taken into account during disability determinations.

HIV-1 is the technical name for the type of HIV that is causing AIDS in most of the world. Unless otherwise stated, reference to HIV in the listings and discussion means HIV-1. Another form of HIV—HIV-2—can also cause AIDS, but

it is confined mostly to West Africa. HIV-2 progresses more slowly than HIV-1, but could potentially qualify under the listing if such a case were encountered.

HIV is a type of retrovirus, which multiplies by taking over the genetic material of the host cells it infects. The host cells, such as CD4 lymphocytes, are killed in the process. HIV can also lie dormant in various kinds of host cells they have not killed, so that even if the virus is completely wiped out of the bloodstream, a recurrence of infection can occur if medication is stopped. Once a person is infected with HIV, it will probably not be possible to ever completely eliminate it from the body.

HIV-1 has been thought to consist of two major groups of viruses that can infect humans and cause AIDS: the M ("Majority") group and the O ("Outlier") group. There are nine subtypes of Group M (A through I). However, a newer virus, found in 1995 in Africa, called YBF30, has been designated as a new group N. Conventional HIV tests, including those done on blood supplies, do not detect YBF30. The spread of YBF30 has been limited, but that may not remain the case.

HIV is the most serious infectious agent facing the world today. About 80% of those who are infected with HIV are known as typical progressors with a median survival of ten years. About 10–15% of people with HIV infection are "rapid progressors," with a median survival of only two or three years. About 5–10% of those infected are "non-progressors," who remain without symptoms for as long as ten years.

Specific requirements for disability based on HIV infection can be found in Listing 14.08 for adults, or Listing 114.08 for children. Additional comments may also be found there.

c. Inflammatory Arthritis

Inflammatory arthritis isn't simply one disease—it is associated with a number of disorders, whose cause, nature and severity of flare-ups and outcome may differ dramatically. Depending on the type of inflammatory arthritis, there may be involvement of the peripheral joints, the spine, or both. Spinal involvement is found especially in cases caused by psoriasis, ankylosing spondylitis, Reiter's syndrome, Behcet's disease, Whipple's disease or by unknown factors (undifferentiated spondylitis). Inflammation of the soft tissues around joints is usually evaluated under SSA Listing 14.09 (adults) or 114.09 (children). To the extent bony joint damage with deformity is present as a result of inflammation, SSA evaluation would be done under Listing 1.02 or 1.03 (adults). Similarly, the SSA would evaluate deformity under Listing 101.02 or 101.03 (children).

The abnormalities that sometimes accompany the various disorders causing inflammatory arthritis may be found in numerous body systems other than the joints. For example, these disorders may include:

- inflammation of the eye
- inflammation of the membranes lining the chest and covering the lungs (pleuritis)
- fibrosis of the lungs
- inflammation of the heart muscle (myocarditis) or pericardium (pericarditis)
- abnormal heart rhythms (cardiac arrhythmias)
- damage to heart valves
- inflammation of arteries supplying the heart (coronary arteritis)
- Raynaud's phenomena
- inflammation of arteries generally (systemic vasculitis)
- amyloidosis of the kidney
- chronic anemia
- decreased blood platelets (thrombocytopenia)
- neuropathy, or other neurological abnormalities, or
- inflammation of heel ligaments (heel enthesopathy).

In children, inflammation of joints and other organs may affect growth, development, attainment of age-appropriate skills and performance of age-appropriate activities. If the child has growth impairments, the SSA would evaluate these under Listings 100.01 and 100.02.

The SSA cannot find you disabled simply because treatment of your arthritis requires the chronic use of steroid drugs. Each case must be evaluated on its own merits, taking into consideration the severity of the underlying impairment and any other adverse consequences of treatment, such as steroid drug side effects.

B. Specific Listings and Residual Functional Capacity

The listings that follow are from the federal regulations. I have interpreted and commented on them for greater ease of understanding while explaining their requirements. It is impossible to discuss here all of the medical possibilities related to every kind of disorder, and you may need to seek help from your treating doctor to more fully understand how your particular impairment relates to these listings. The discussions of residual functional capacity do not apply to children.

1. Listing 14.02: Systemic Lupus Erythematosus (Adults)

Systemic lupus erythematosus (SLE) is an autoimmune disorder, which means the body's immune system reacts against healthy tissues. Almost any part of the body can be involved, including the nervous system, kidneys, intestine, skin, muscles, joints, eyes, lungs, bone marrow or heart. That is why SLE is referred to as a multisystem disorder. SLE may show periods of increased severity (exacerbations) involving a particular organ, followed by some degree of improvement and involvement of some other organ. Or, multiple organs may be involved in different degrees of severity at the same time. SLE is caused by genetic abnormalities that are more common in females and people of Asian heritage.

The damage and symptoms caused by SLE vary greatly. Some people have mild disease controllable with medication and few symptoms, while others have rapidly progressive disease despite treatment. A particularly ominous problem is decreased kidney function related to SLE damage.

SLE may produce constitutional symptoms and signs such as fever, fatigability, malaise and weight loss. Other possible problems include anemia, a decreased white cell count (leukopenia) or a decreased platelet count (thrombocytopenia). A variety of circulating serum autoantibodies directed against the patient's own tissues can occur, but are highly variable in pattern.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must be diagnosed as suffering from systemic lupus erythematosus. Additionally, you must satisfy part ① or ②.

① One of the following:

- Joint involvement, as described under the criteria in listings with 1 as the prefix (Chapter 16)
- Muscle involvement, as described under the criteria in Listing 14.05 (this chapter)
- Eye involvement, as described under the criteria in listings with 2 as the prefix (Chapter 17)
- Respiratory involvement, as described under the criteria in listings with 3 as the prefix (Chapter 18)
- Heart or blood vessel involvement, as described under the criteria in listings with 4 as the prefix (Chapter 19) or 14.04② (this chapter)
- Digestive involvement, as described under the criteria in listings with 5 as the prefix (Chapter 20)
- Kidney involvement, as described under the criteria in listings with 6 as the prefix (Chapter 21)

- Blood involvement, as described under the criteria in listings with 7 as the prefix (Chapter 22)
- Skin involvement, as described under the criteria in listings with 8 as the prefix (Chapter 23)
- Nervous system involvement, as described under the criteria in listings with 11 as the prefix (Chapter 26), or
- Mental involvement, as described under the criteria in listings with 12 as the prefix (Chapter 27).

Ⓐ Significant (more than slight) damage to at least one of the organs or body systems listed in part Ⓐ, and at least slight damage to another. For example, you could have significantly painful hand joints and a minor inflammation of the eye. Additionally, you must have significant constitutional symptoms and signs of severe fatigue, fever, malaise and weight loss documented in your medical records. Significant constitutional symptoms and signs would be those sufficiently severe to have more than a slight effect in your ability to function in your daily activities or a work environment. Medical judgment on a case-by-case basis is required to make the above determinations.

b. Residual Functional Capacity

Since SLE can affect so many different areas of the body, each case must be evaluated on an individual basis. SLE can cause feelings of weakness and fatigue that are not obvious on physical examination. Also, lupus often causes the skin to be hypersensitive to sunlight. A claimant with this should not be given an outdoor job. There is a disorder affecting only the skin, called discoid lupus. This is not as serious as systemic lupus, but should still receive restrictions on exposure to excessive sunlight. Reference should also be made to comments about RFC under whatever body system and specific listings are most relevant to the claimant's problems. For example, eye involvement would be evaluated under the listings described in Chapter 17 and whatever RFC discussions are appropriate to the specific impairment involved. As another example, SLE can result in abnormalities of the blood, including anemia, thrombocytopenia and leukopenia. Anemia can lead to decreased exercise tolerance and weakness; thrombocytopenia can lead to an excessive tendency to bleed; and leukopenia can produce susceptibility to infection. Various RFC possibilities related to these blood disorders can be found in Chapter 22.

2. Listing 114.02: Systemic Lupus Erythematosus (Children)

See the comments under adult Listing 14.02.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have a diagnosis of systemic lupus erythematosus. Additionally, the child must satisfy part Ⓐ or part Ⓑ, below.

Ⓐ One of the following:

- Growth impairment, as described under the criteria in listings with 100 as the prefix (Chapter 16)
- Musculoskeletal involvement, as described under the criteria in listings with 101 as the prefix (Chapter 16)
- Muscle involvement, as described under the criteria in Listing 14.05 (this chapter)
- Eye involvement, as described under the criteria in listings with 102 as the prefix (Chapter 17)
- Respiratory involvement, as described under the criteria in listings with 103 as the prefix (Chapter 18)
- Heart or blood vessel (cardiovascular) involvement, as described under the criteria in listings with 104 as the prefix (Chapter 19) or 14.04Ⓐ (this chapter)
- Digestive involvement, as described under the criteria in listings with 105 as the prefix (Chapter 20)
- Kidney involvement, as described under the criteria in listings with 106 as the prefix (Chapter 21)
- Blood involvement, as described under the criteria in listings with 107 as the prefix (Chapter 22)
- Skin involvement, as described under the criteria in listings with 8 as the prefix (Chapter 23)
- Hormone (endocrine) involvement, as described under the criteria in listings with 109 as the prefix (Chapter 24)
- Nervous system involvement, as described under the criteria in listings with 111 as the prefix (Chapter 26), or
- Mental involvement, as described under the criteria in listings with 112 as the prefix (Chapter 27).

Ⓑ Significant (more than slight) damage to at least one of the organs or body systems listed in part Ⓐ, and at least slight damage to another. For example, the child could have significant anemia and a minor growth impairment. Additionally, the child must have significant constitutional symptoms and signs of severe fatigue, fever, malaise and weight loss documented in her medical records. Significant constitutional symptoms and signs would be those sufficiently severe to have more than a slight effect in the child's ability to function in age-appropriate daily activities. Medical judgment on a case-by-case basis is required to make the above determinations.

3. Listing 14.03: Systemic Vasculitis (Adults)

Systemic vasculitis means generalized inflammation of the arterial system. It occurs acutely in association with adverse drug reactions, certain chronic infections and, occasionally, cancers. More often it is chronic and of unknown origin. There are several clinical patterns, including (but not limited to) classical polyarteritis nodosa, aortic arch arteritis, giant cell arteritis, Wegener's granulomatosis and vasculitis associated with other disorders (for example, rheumatoid arthritis, systemic lupus erythematosus (SLE), Sjogren's syndrome, cryoglobulinemia).

The diagnosis is confirmed by angiography or tissue biopsy when the disease is suspected from a clinical evaluation. These studies must be done to satisfy the listing. However, the SSA does not request or perform angiography or biopsies, since these are invasive procedures. Most patients with systemic vasculitis will have the results of the angiogram or biopsy in their medical records.

Vasculitis of the skin may or may not be associated with systemic involvement, and the patterns of vascular involvement are highly variable. Such skin involvement may include decreased blood flow to areas of skin (ischemia).

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must be diagnosed with systemic vasculitis. Additionally, you must satisfy part **A** or **B**, below.

- A** Involvement of a single organ or body system, as described under the criteria in Listing 14.02^A above.
- B** Significant (more than slight) damage to at least one of the organs or body systems listed in part **A**, and at least slight damage to another. For example, you could have significant cardiac arrhythmias and minor joint inflammation. Additionally, you must have significant constitutional symptoms and signs of severe fatigue, fever, malaise and weight loss documented in your medical records. Significant constitutional symptoms and signs would be those sufficiently severe to have more than a slight effect on your ability to function in your daily activities or a work environment. Medical judgment on a case-by-case basis is required to make the above determinations.

b. Residual Functional Capacity

You should refer to the comments about RFC under whatever body system and specific listings are most relevant to your physical problems. For example, kidney involvement would be evaluated under the listings described in Chapter 21, including the accompanying RFC discussions.

4. Listing 114.03: Systemic Vasculitis (Children)

This listing has the same requirements as 14.03 above, as well as the additional consideration of growth impairments (Chapter 16).

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must be diagnosed with systemic vasculitis as described in Listing 14.03 or, if there is growth impairment, as described under the criteria in listings with the prefix 100 (Chapter 16).

5. Listing 14.04: Systemic Sclerosis and Scleroderma (Adults)

Systemic sclerosis is an autoimmune disease also known as progressive systemic sclerosis (PSS). The word "progressive" in the acronym PSS does not mean that the disorder must be worsening to qualify under the listing. In fact, the SSA may have removed the word progressive from its listing to avoid such confusion. Systemic sclerosis is the generalized form of this connective tissue disorder, while scleroderma refers to the hardening and thickening of skin. It is possible to have scleroderma without having systemic sclerosis, but systemic sclerosis frequently includes scleroderma.

There are no diagnostic laboratory tests for scleroderma or systemic sclerosis. This is an incurable disease with no very effective treatment other than supportive care and treatment for secondary disorders such as high blood pressure or heart failure.

The clinical hallmark of systemic sclerosis and scleroderma is thickening of the skin. In addition to skin and blood vessels, the major organs and body systems involvement may include the gastrointestinal tract, lungs, heart, kidneys and muscle. Although arthritis can occur, abnormal joint function results primarily from thickening of the skin and other soft tissue, as well as fibrosis and contractures. Scleroderma itself, even without systemic sclerosis, can cause degeneration not only of skin, but of underlying soft tissues such as muscle, ligaments and tendons.

There is a disorder known as the CREST syndrome that may slowly progress to systemic sclerosis over a period of years. CREST stands for **C**alcinosis, **R**aynaud's phenomena, **E**sophageal dysmotility, **S**clerodactyly and **T**elangiectasia. These disorders are defined at the beginning of this chapter. Refer to these definitions if you see the term CREST in your medical file or other SSA documents.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have a diagnosis of systemic sclerosis and scleroderma. Additionally, you must satisfy part ①, ②, ③ or ④, below.

- ① One of the following:
- Muscle involvement, as described under the criteria in Listing 14.05.
 - Respiratory involvement, as described under the criteria in listings with 3 as the prefix (Chapter 18)
 - Heart or blood vessel (cardiovascular) involvement, as described under the criteria in listings with 4 as the prefix (Chapter 19)
 - Digestive involvement, as described under the criteria in listings with 5 as the prefix (Chapter 20), or
 - Kidney involvement, as described under the criteria in listings with 6 as the prefix (Chapter 21).
- ② Significant (more than slight) damage to at least one of the organs or body systems listed in part ①, and at least slight damage to another. For example, you could have a significant problem with scleroderma and a minor degree of lung fibrosis. Additionally, you must have significant constitutional symptoms and signs of severe fatigue, fever, malaise and weight loss documented in your medical records. Significant constitutional symptoms and signs would be those sufficiently severe to have more than a slight effect in your ability to function in your daily activities or a work environment. Medical judgment on a case-by-case basis is required to make the above determinations.
- ③ Generalized scleroderma with digital contractures. This means there is a generalized hardening of the skin, as well as inability to move the fingers normally as a result of hardening of the soft tissues around them. There is no requirement that the fingers have to be fixed to such a degree that no movement is possible.
- ④ Severe Raynaud's phenomena, characterized by digital ulcerations, ischemia or gangrene. This part of the listing concerns the complication of decreased blood flow (ischemia) to the fingers as a result of Raynaud's phenomenon. Gangrene may appear as black spots, especially on the fingertips, which is evidence of severe ischemia. If the gangrenous tissue sloughs off, it leaves ulcers.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from systemic sclerosis or scleroderma and the treatment given. Particular attention should be given to the ability to use the hands. Even if gross function is intact, fine (small) movements with

the fingers may be affected and limit the kinds of work that you can perform. Reference should also be made to comments about RFC under whatever body system and specific listings are most relevant to your problems. For example, heart involvement would be evaluated under the listings described in Chapter 19 and the accompanying RFC discussions.

6. Listing 114.04: Systemic Sclerosis and Scleroderma (Children)

See comments under adult Listing 14.04 above, with the additional consideration of possible growth impairments, which would be evaluated under the 100-prefix listings (Chapter 16).

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have a diagnosis of systemic sclerosis and scleroderma. Additionally, the child must satisfy part ① or ②, below.

- ① See the criteria in Listing 14.04 or, if there is growth impairment, see the criteria in listings with 100 as the prefix (Chapter 16).
- ② Linear scleroderma. In linear scleroderma, areas of skin abnormality appear as lines or bands rather than the patchy shape characteristic of most scleroderma. In addition, 1, 2, 3 or 4 must be satisfied.
1. Fixed valgus or varus deformities of both hands or both feet. These are deformities in which the hands or feet are bent in a fixed position away from or toward the body.
 2. Marked destruction or marked atrophy of an extremity. This requirement is satisfied by damage to an arm or leg so severe that it has no useful function.
 3. Facial disfigurement from hypoplasia of the mandible, maxilla or zygoma resulting in a mental disorder, as described under the criteria in listings with 112 as the prefix (Chapter 27).
 4. Seizure disorder, as described under the criteria in listings with 111 as the prefix (Chapter 26).

7. Listing 14.05: Polymyositis or Dermatomyositis (Adults)

Polymyositis or dermatomyositis are autoimmune diseases. They are primarily inflammatory processes found in striated muscles, which control bone movement. Both diseases can occur alone or in association with other connective tissue disorders or malignancy. Polymyositis and dermatomyositis are thought to be part of the same disorder, but with der-

matomyositis the skin also becomes inflamed. While the muscle inflammation caused by these diseases can often be effectively treated, the cause of the disease is unknown and there is no cure. The majority of cases (65–75%) will respond to corticosteroid drugs, such as prednisone, which suppress the abnormal immune system process inflaming the muscles (myositis). Other drugs (for example, methotrexate, azathioprine) that suppress the immune system may also be tried. Any muscles can be affected.

There are no tests that clearly diagnose polymyositis or dermatomyositis. Diagnosis is partly based on the exclusion of other disorders like muscular dystrophy, metabolic diseases, endocrine diseases, drug side effects and infections.

The diagnosis is supported by elevated serum muscle enzymes, characteristic abnormalities on electromyography and myositis seen through a muscle biopsy. CPK and aldolase enzymes can be measured by a simple blood test to determine if the disease is worsening or responding to therapy, as higher levels indicate greater muscle inflammation. The SSA should consider elevations in these enzymes as strong evidence that weakness and fatigability are real and limiting. By looking at the laboratory reports in your own medical records, you can determine whether the enzymes are elevated, because the test reports will include your results and the expected values in a normal person. You can also find out whether the results of enzyme tests are abnormal from your treating doctor or medical books available in most bookstores or libraries. It is quite possible that the SSA could send you for a blood test to measure enzyme levels. Such tests can help the SSA determine the severity of your disease. That is relevant to the listing and any possible RFC, even though enzyme tests are not specifically mentioned by the listing. For example, the SSA is much more likely to believe that you have severe muscle weakness under part ④ of the listing if your muscle enzymes are elevated than if the results are normal.

On the other hand, informed medical judgment is needed to evaluate enzyme tests results, because you could be truly weak and still have normal test results. How is this possible? Steroid drugs—such as prednisone—taken over a period of months can cause muscle weakness, a condition known as steroid myopathy. In this case, the SSA would be in error to dismiss your complaints of muscle weakness based on normal enzyme reports. It is important that the SSA obtain information over as long a period of time as possible, so that an accurate picture can be obtained of your health, rather than a snapshot of your condition at the time you apply for disability.

Electromyography (EMG) should show abnormally decreased electrical activity from significantly inflamed

muscles. Evaluation of biopsy specimens under a microscope should show the characteristic degenerating and regenerating muscle fibers and presence of inflammatory cells. If you see an EMG report, look for mention of these abnormalities showing active muscle inflammation.

Skin lesions associated with dermatomyositis may appear in various forms, including characteristic violaceous patches—lesions with a purplish coloration. Itching may be intense and require treatment with antihistamines or other drugs. The skin should be protected from excessive exposure to sunlight by the use of sunscreens.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have a diagnosis of polymyositis or dermatomyositis. Additionally, you must satisfy part ④, ⑤, ⑥ or ⑦, below.

- ④ Severe proximal limb-girdle (shoulder and/or pelvic) muscle weakness. These are the muscles most likely to be weak. Pain and muscle tenderness may also be present and occasionally are the main symptom. Weakness of the pelvic girdle satisfying this part of the listing would result in significant difficulty climbing stairs or rising from a chair without use of the arms. Proximal limb weakness in the upper extremities may result in inability to lift objects, and interference with dressing and combing the hair.
- ⑤ Less severe limb-girdle muscle weakness than in part ④, associated with neck (cervical) muscle weakness. The anterior neck flexors are muscles that move the head forward in a standing position or upward in a lying (supine) position. Weakness of these flexors satisfies the requirement for muscle weakness in the neck, if the head cannot even be lifted from a pillow. Additionally, 1 or 2 must be present to at least a moderate level of severity, as determined by medical judgment.
 1. Difficulty swallowing (dysphagia) and episodes of aspiration due to cricopharyngeal muscle weakness. The cricopharyngeal muscles are deep in the neck and just above the beginning of the esophagus; weakness of these muscles could result in dysphagia; episodes of aspiration can occur by getting food into the trachea and the lungs (aspiration). The muscles in the upper part of the esophagus may also be weakened, increasing the chances of aspiration. Note that while aspiration of food contents into the trachea can easily result in pneumonia, it is not a requirement of the listing.
 2. Impaired breathing due to intercostal and diaphragmatic muscle weakness. The intercostal muscles, located between the ribs, are important for proper

breathing. The diaphragm consists of two sheets of muscle between the chest and abdomen and is also important in respiration.

- © Association with a cancerous tumor, as described under the criteria in listings with 13 as a prefix (Chapter 28).
- ⑩ Association with generalized connective tissue disease, described under the criteria in Listings 14.02, 14.03, 14.04 or 14.06. If you examine those listings, they further refer to additional listings, such as those dealing with musculoskeletal impairments (Chapter 16), breathing disorders (Chapter 18) or heart disease (Chapter 19). The following facts are relevant to part ⑩:
 - It is possible to have isolated dermatomyositis with skin involvement which may precede the development of polymyositis by several years in about 10% of cases.
 - Polymyositis or dermatomyositis are known to be associated with a much higher risk than normal of developing some form of cancer, especially in older adults.
 - Breathing difficulties can result from fibrosis of lung tissue itself, in addition to weakness of the muscles of respiration.
 - Some patients also have painful, inflamed joints.
 - The heart muscle may be inflamed (myocarditis), but only in a few patients.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the polymyositis or dermatomyositis and treatment. As stated above, chronic use of steroid drugs can weaken muscles and should be considered a source of possible weakness even if muscle inflammation is under control. There should be avoidance of prolonged, intense sunlight exposure. Reference should also be made to comments about RFC under whatever body system and specific listings are most relevant to your problems.

8. Listing 114.05: Polymyositis or Dermatomyositis (Children)

See comments under adult Listing 14.05. Part ⑥ provides additional possible criteria for allowance.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have a diagnosis of polymyositis or dermatomyositis. Additionally, the child must satisfy part ① or ②, below.

① See the criteria in adult Listing 14.05.

② With one of the following:

1. Multiple fixed joints (joint contractures). Multiple only means more than one joint must be involved. One hand and wrist together count as one joint; individual finger joints cannot be counted separately.
2. Generalized skin calcification with formation of a hard crust outside the skin (exoskeleton). The child's entire skin surface does not have to be covered with calcium deposits. The skin must be involved generally, rather than at one or two locations.
3. Generalized arterial inflammation (systemic vasculitis) as described in Listing 14.03.

9. Listing 14.06: Undifferentiated Connective Tissue Disorder (Adults)

This listing deals with tissue disorder syndromes that have clinical (physical) and immunologic (laboratory) features of several connective tissue disorders, but that do not satisfy the criteria for any of the disorders described in other listings. For instance, there may be overlap syndromes with the signs and symptoms of rheumatoid arthritis and scleroderma. Or there may be clinical findings of systemic lupus and systemic vasculitis, but blood tests that confirm findings of rheumatoid arthritis. The correct diagnosis of undifferentiated connective tissue disorder is important for determining prognosis.

No actual evaluation is done under this listing. Claimants are evaluated under other listings or a combination of listings. The important point is that the SSA not disregard abnormalities that don't fit into a neat diagnostic category.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have a diagnosis of undifferentiated connective tissue disorder with impairment as described under the criteria in Listings 14.02①, 14.02② or 14.04.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the connective tissue disorder and treatment given. See the RFC discussion under whatever listing is used for evaluation.

10. Listing 114.06: Undifferentiated Connective Tissue Disorder (Children)

See comments under adult Listing 14.06.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have a diagnosis of undifferentiated connective tissue disorder with impairment as described under the criteria in Listings 114.02 or 114.04.

11. Listing 14.07: Immune Deficiency Disorders Other Than Those Caused by HIV (Adults)

This listing deals with disorders associated with decreased immunity other than those caused by human immunodeficiency virus (HIV) infection, which is considered under another listing. Immune deficiency disorders are those in which there is either a deficiency of some type of antibody (immunoglobulin) or white cells that play an important role in the immune system. Immunity involving antibodies is known as humoral immunity, while immunity involving white cells is known as cell-mediated immunity. Antibodies are produced by white cells known as B lymphocytes, while in cell-mediated immunity T lymphocytes (for example, CD4 (T4) lymphocytes) play a direct role in controlling infection. This listing can be used for either type of immunity.

Various types of immune deficiency may be present at birth or arise later in life. Adult deficiencies not associated with HIV infection are more often an antibody deficiency than a white cell deficiency. There may be a deficiency of one or more types of antibody. For example, combined variable immunodeficiency disorder can occur in adults, especially in association with autoimmune diseases like systemic lupus erythematosus (SLE), and involves the deficiency of multiple types of antibodies. Antibody deficiencies can be treated with immunoglobulin injections to bring them back to normal levels.

Infection is the risk for those with antibody deficiencies, especially IgG or IgM. Therefore, the listing deals with repeated medically severe infections. Most likely, such infections would result in hospitalization and treatment with intravenous antibiotics, but hospitalization is not a requirement of the listing.

Various kind of bodily damage done by recurrent infection might require evaluation under another listing. For example, repeated episodes of pneumonia could result in chronic lung damage. If this listing is not satisfied, evaluation would then also be done under the breathing disorder listings (Chapter 18).

a. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have a diagnosis of immune deficiency disorders other than those caused by HIV associated with docu-

mented, recurrent severe infection occurring three or more times within a five-month period.

b. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the immune deficiency disorder and treatment given. Recurrent severe infections can result in so much time being sick and receiving treatment that physical strength and stamina can be affected. Reference should also be made to the discussions of RFC for particular disorders that might result as a complication of bacterial infections, such as the RFCs discussed in regard to lung disease caused by repeated pulmonary infections (Chapter 18). Damage to the kidneys would be evaluated under the listing for kidney disorders (Chapter 21).

12. Listing 114.07: Congenital Immune Deficiency Disease (Children)

See the comments under adult Listing 14.07. You may encounter listings using the words "gamma globulin." That is an old way of referring to immunoglobulins, but remains part of the name of some medical disorders. In congenital hypogammaglobulinemia there is a decrease in all types of antibodies. In congenital dysgammaglobulinemia there is a decrease in some types of antibodies. The risk of severe infection accompanies extremely low antibody levels. Other abnormalities, such as described in part A2 below, may also be present.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have a diagnosis of congenital immune deficiency disease and either part A or B, below.

A Hypogammaglobulinemia or dysgammaglobulinemia, with:

1. Documented, recurrent severe infections occurring three or more times within a five-month period, or
2. An associated disorder such as growth retardation, chronic lung disease, connective tissue disorder or tumor. Evaluate according to the appropriate body system listing.

B Thymic dysplastic syndromes (such as Swiss or diGeorge). The thymus gland in the neck plays an important role in the immune system, especially in developing cell-mediated immunity. The Swiss and diGeorge syndromes are rare congenital disorders involving a poorly developed or abnormal thymus. The risk of se-

vere infection is so high that these diagnoses alone are sufficient for allowance.

13. Listing 14.08: Human Immunodeficiency Virus (HIV) Infection (Adults)

a. General Information

Human immunodeficiency virus (HIV) infection is caused by a type of retrovirus. HIV weakens the immune system by destroying CD4 (T4) lymphocytes. By suppressing the immune system, HIV infection makes an infected person susceptible to one or more opportunistic diseases, cancers or other conditions described in this listing. Any person with HIV infection, including one with a diagnosis of acquired immunodeficiency syndrome (AIDS), may be found disabled under this listing if his or her impairment meets any of the criteria in this listing or is of equivalent severity to any impairment in this listing.

b. Definitions

In this listing, the meanings of the terms “resistant to treatment,” “recurrent” and “disseminated” used by the SSA have the same general meaning as used by the medical community. The precise meaning of any of these terms will depend upon the specific disease or condition in question, the body system affected, the usual course of the disorder and its treatment and the other circumstances of the case.

- “Resistant to treatment” means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate, or a course of treatment appropriate, will depend on the facts of the particular case.
- “Recurrent” means that a condition that responded adequately to an appropriate course of treatment has returned after a period of remission or regression. The extent of response (or remission) and the time periods involved will depend on the facts of the particular case.
- “Disseminated” means that a condition is spread widely over a considerable area or body system(s). The type and extent of the spread will depend on the specific disease.
- As used in Part I of the listing, “significant involuntary weight loss” does not correspond to a specific minimum amount or percentage of weight loss, although, for purposes of this listing, an involuntary weight loss of at least 10% of baseline is always considered significant. Loss of less than 10% may or may not be significant, depending on the individual’s

baseline weight and body build (also called *habitus*). For example, a seven-pound weight loss in a 100-pound female who is 63 inches tall might be considered significant; but a 14-pound weight loss in a 200-pound female who is the same height might not be significant.

c. Manifestations Specific to Women

Most women with severe suppression of their immune system caused by HIV infection show the typical opportunistic infections and other conditions, such as pneumocystis carinii pneumonia (PCP), yeast fungal infection of the esophagus (candida esophagitis), extreme malnutrition and weight loss (wasting syndrome), cryptococcosis (cryptococcal fungal infection) and toxoplasmosis. However, HIV infection may have different manifestations in women than in men. Doctors working for the SSA must carefully evaluate the medical evidence and be alert to the variety of medical conditions specific to or common in women with HIV infection that may affect their ability to function in the workplace.

Many of these manifestations (for example, vulvovaginal candidiasis, pelvic inflammatory disease) occur in women with or without HIV infection, but can be more severe or resistant to treatment, or occur more frequently in a woman whose immune system is suppressed. Vulvovaginal candidiasis is a yeast fungal infection of the female genitalia; pelvic inflammatory disease (PID) refers to infection involving the female reproductive organs: the ovaries, fallopian tubes or uterus. Therefore, when evaluating the claim of a woman with HIV infection, it is important to consider gynecologic and other problems specific to women, including any associated symptoms (for example, pelvic pain), in determining the severity of the impairment and resulting functional limitations. Manifestations of HIV infection in women may be evaluated under the specific criteria (for example, cervical cancer under part ④), under an applicable general category (for example, pelvic inflammatory disease under part ④5) or, in appropriate cases, under part ④.

d. Evaluation

The criteria in this listing do not describe the full spectrum of diseases or conditions manifested by people with HIV infection. As in any case, consideration must be given to whether an individual’s impairment meets or equals in severity any other listing (for example, the cancer listings with prefixes of 13 in Chapter 28). Although this listing includes cross-references to other listings for the more common manifestations of HIV infection, additional other listings may also apply.

In addition, the effect of all impairments on the claimant, whether or not related to HIV infection, must be considered. For example, individuals with HIV infection may manifest signs and symptoms of a mental impairment (for example, anxiety and depression), or of another physical impairment. Medical evidence should include documentation of all physical and mental impairments, and the impairments should be evaluated not only under other listings mentioned in Listing 14.08, but under any other appropriate listings.

e. Documentation of HIV Infection

The medical evidence must include documentation of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

i. Documentation of HIV Infection by Definitive Diagnosis

A definitive diagnosis of HIV infection is documented by one or more of the following laboratory tests:

- A serum specimen that contains HIV antibodies. HIV antibodies are usually detected by a screening test. The most commonly used screening test is the ELISA. Although this test is highly sensitive, it may yield false positive results. Therefore, positive results from an ELISA must be confirmed by a more definitive test, such as the Western blot or immunofluorescence assay (IFA).
- A specimen that contains immune-reactive parts of the human immunodeficiency virus (HIV antigen), such as serum specimens, lymphocyte cultures or cerebrospinal fluid (CSF) specimens.
- Other tests that are highly specific for detection of HIV, such as polymerase chain reaction (PCR), or that are acceptable methods of detection consistent with the prevailing state of medical knowledge.

When laboratory testing for HIV infection has been performed, the SSA must make every reasonable effort to obtain the results of that testing.

Individuals who have HIV infection or other disorders of the immune system may undergo tests to determine the T-helper lymphocyte (CD4) count in the blood, because CD4 cells are destroyed by HIV. The extent of immune depression correlates with the level or rate of decline of the CD4 count. In general, when the CD4 count is 200/mm³ or less (14% or less), the susceptibility to opportunistic disease is considerably increased. CD4 lymphocytes are necessary for effective cell-mediated immunity, and such immunity declines as the number of CD4 cells in the blood fall. However, a low CD4 count alone does not establish a definite

diagnosis of HIV infection. Nor will it document the severity or functional effects of HIV infection.

ii. Other Acceptable Documentation of HIV Infection

HIV infection may also be documented without the definitive laboratory tests described above, if such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, HIV infection may be documented by the medical history, clinical and laboratory findings and diagnoses indicated in the medical evidence.

For example, a diagnosis of HIV infection will be accepted without definitive laboratory evidence if the claimant has an opportunistic disease, such as toxoplasmosis of the brain or pneumocystis carinii pneumonia (PCP). Toxoplasmosis and PCP are caused by protozoan organisms that only seriously infect people with weak immune systems. Their presence strongly suggests that the person has a defect in cell-mediated immunity caused by a low CD4 lymphocyte count. However, to reach this conclusion without definitive laboratory evidence of HIV infection there must be no other known cause of diminished resistance to the opportunistic disease concerned. For instance, long-term steroid treatment and lymphoma-type cancer can also suppress the immune system. In all cases without definitive laboratory evidence of HIV infection, the SSA must make every reasonable effort to obtain full details of the history, medical findings and results of testing. Problems can arise if the treating doctor, hospital or other medical facility has lost the records documenting HIV infection, or simply refuses to give them to the SSA.

f. Documentation of Manifestations of HIV Infection

A person infected with HIV may not have any symptoms, much less any opportunistic diseases or other functional limitations. Therefore, the medical evidence must also include documentation of any possibly disabling manifestations of HIV infection. Such manifestations could include, for example, opportunistic infections such as pneumocystis carinii pneumonia, or cancer. Such manifestations would justify a diagnosis of AIDS. While claimants with impairments that satisfy the listing would generally be considered to have AIDS, the listing itself does not mention AIDS, because it is the severity of the impairments that matters, not whether there is a diagnosis of AIDS. A treating doctor cannot establish severity on the basis of diagnosis. Documentation of manifestations of HIV infection may be by laboratory evidence or by other generally acceptable meth-

ods consistent with the prevailing state of medical knowledge and clinical practice.

i. Documentation of Manifestations of HIV Infection by Definitive Diagnosis

The definitive method of diagnosing opportunistic diseases or conditions that are manifestations of HIV infection is by culture, serological test or microscopic examination of biopsied tissue or other material (for example, bronchial washings). Therefore, the SSA must make every reasonable effort to obtain specific laboratory evidence of an opportunistic disease or other condition whenever this information is available. If a test of tissue (histological test) or other test has been performed, the evidence should include a copy of the appropriate report. If the report is not obtainable, the summary of hospitalization or a report from the treating source should include details of the findings and results of the diagnostic studies (including x-ray reports) or microscopic examination of the appropriate tissues or body fluids. Various test reports can be unobtainable for a variety of reasons, such as loss or simply refusal by a treating doctor, hospital or other facility to give the information to the SSA.

Although a reduced CD4 lymphocyte count may show that there is an increased susceptibility to opportunistic infections and diseases, that alone does not establish the presence, severity or functional effects of a manifestation of HIV infection.

ii. Other Acceptable Documentation of Manifestations of HIV Infection

Manifestations of HIV infection may also be documented without the definitive laboratory evidence described in Section a, above, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and other evidence. If no definitive laboratory evidence is available, manifestations of HIV infection may be documented by medical history, clinical and laboratory findings and diagnoses indicated in the medical evidence. In such cases, the SSA must make every reasonable effort to obtain full details of the history, medical findings and results of testing.

Documentation of cytomegalovirus (CMV) disease (part ④) presents special problems, because diagnosis requires identification of viral inclusion bodies or a positive culture from the affected organ, and the absence of any other infectious agent. A positive serology test identifies infection with the virus, but does not confirm a disease process. With the exception of chorioretinitis (which may be diagnosed by an ophthalmologist), documentation of CMV disease re-

quires confirmation by biopsy or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

g. Effect of Treatment

Medical treatment must be considered in terms of its effectiveness in decreasing the signs, symptoms and laboratory abnormalities of the specific disorder, or of the HIV infection itself. For example, the antiretroviral drugs used to treat HIV and AIDS may have side effects of treatment that may further impair a claimant.

Response to treatment and adverse or beneficial consequences of treatment may vary widely. For example, an individual with HIV infection who develops pneumonia or tuberculosis may respond to the same antibiotic regimen used in treating people without HIV infection, but another person with HIV infection may not respond to the same regimen. Therefore, each case must be considered on an individual basis, along with the effects of treatment on the person's ability to function.

A specific description of the drugs or treatment given (including surgery), dosage, frequency of administration and a description of the complications or response to treatment should be obtained. The effects of treatment may be temporary or long-term. As such, the decision regarding the impact of treatment should be based on a sufficient period of treatment to permit proper consideration.

h. Functional Criteria

Part ④ of this listing establishes standards for evaluating manifestations of HIV infection that do not meet the requirements listed in parts ① through ③.

For individuals with HIV infection evaluated under part ④, listing-level severity will be assessed in terms of the functional limitations imposed by the impairment. The full impact of signs, symptoms and laboratory findings on the claimant's ability to function must be considered. Important factors to be considered in evaluating the functioning of people with HIV infection include, but are not limited to:

- symptoms, such as fatigue and pain
- characteristics of the illness, such as the frequency and duration of manifestations or periods of worsening (exacerbation) and improvement (remission), and
- the effect of the treatment for the disease on the claimant's ability to function, including the side effects of medication.

As used in part ④, "repeated" means that:

- The conditions occur on an average of three times a year, or once every four months, each lasting two weeks or more, or

- The conditions do not last for two weeks but occur substantially more frequently than three times in a year or once every four months, or
- The conditions occur less often than an average of three times a year or once every four months, but last substantially longer than two weeks at a time.

To meet the criteria in part ⑨, an individual with HIV infection must demonstrate a marked level of restriction in one of three general areas of functioning:

- activities of daily living (ADLs)
- social functioning, and
- difficulties in completing tasks due to deficiencies in concentration, persistence or speed of work (pace).

Functional restrictions may be caused by the effect of the disease process on mental or physical functioning, or both. For example, these effects could result from extended or intermittent symptoms, such as depression, fatigue or pain, resulting in a limitation of the ability to concentrate, to persevere at a task or to perform the task at an acceptable rate of speed. Limitations may also result from the side effects of medication.

When “marked” is used as a standard for measuring the degree of functional limitation, it means more than moderate, but less than extreme. A marked limitation does not represent a quantitative measure of the person’s ability to do an activity for a certain percentage of the time. A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. However, a claimant need not be totally unable to perform an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively. The term “marked” does not imply that the impaired person is confined to bed, hospitalized or in a nursing home.

Activities of daily living include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation and paying bills. A person with HIV infection who, because of symptoms such as pain imposed by the illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance, would have marked limitation of activities of daily living. This would be true even though he or she is able to perform some self-care activities.

Social functioning includes the capacity to interact appropriately and communicate effectively with others. A person with HIV infection who, because of symptoms or a pattern of worsening and improvement caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though they are able to communicate with

close friends or relatives) would have marked difficulty maintaining social functioning.

Completing workplace tasks in a timely manner involves the ability to sustain concentration, persistence or pace. An individual with HIV infection who, because of HIV-related fatigue or other symptoms, is unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he is able to do routine activities of daily living) would have marked difficulty completing tasks.

i. Listing Level Severity

For your condition to be severe enough to meet this listing, you must have a diagnosis of human immunodeficiency virus (HIV) infection and your condition must match ①, ②, ③, ④, ⑤, ⑥, ⑦, ⑧, ⑨, ⑩, ⑪, ⑫, ⑬, ⑭ or ⑮, below.

① Bacterial infections:

1. Mycobacterial infection such as tuberculosis (TB) or related infections (for example, *M. avium*-intracellular, *M. kansasii*) at a site other than the lungs, skin or cervical or hilar lymph nodes. Also, pulmonary tuberculosis resistant to treatment qualifies under this part of the listing.
2. Nocardiosis.
3. Salmonella bacteria in the blood (bacteremia), recurrent nontyphoid type.
4. Syphilis. Evaluate under the criteria for the affected body system, such as the listings dealing with vision (listings with a 2 prefix, Chapter 17), blood vessels (listings with a 4 prefix, Chapter 19) or the nervous system (listings with an 11 prefix, Chapter 26).
5. Multiple or recurrent bacterial infections, including infections of the female reproductive organs (pelvic inflammatory disease), requiring hospitalization or intravenous antibiotic treatment three or more times in one year.

② Fungal infections:

1. Aspergillosis.
2. Candidiasis, at a site other than the skin, urinary tract or intestinal tract. Also, candidiasis at a site other than the mucous membranes of the mouth, vulva or vagina. Candidiasis involving the esophagus, trachea, bronchi or lungs qualifies under this part of the listing.
3. Coccidioidomycosis, at a site other than the lungs or lymph nodes.
4. Cryptococcosis, at a site other than the lungs (for example, cryptococcal meningitis).
5. Histoplasmosis, at a site other than the lungs or lymph nodes.
6. Mucormycosis.

③ Protozoan or parasitic worm (helminthic) infections:

1. Cryptosporidiosis, isosporiasis or microsporidiosis protozoan infections, with diarrhea lasting for one month or longer.
 2. Pneumocystis carinii pneumonia or pneumocystis carinii infection occurring outside of the lungs.
 3. Strongyloidiasis parasitic worm infection occurring outside of the intestines.
 4. Toxoplasmosis protozoan infection of an organ other than the liver, spleen or lymph nodes.
- Ⓓ Viral infections:
1. Cytomegalovirus disease at a site other than the liver, spleen or lymph nodes.
 2. Herpes simplex virus causing:
 - a. Skin or mucous membrane infection affecting the mouth, genitals or perianal region, lasting for one month or longer, or
 - b. Infection at a site other than the skin or mucous membranes (for example, bronchitis, pneumonitis, esophagitis or encephalitis), or
 - c. Infection that has spread widely throughout the body.
 3. Herpes zoster, either disseminated or with eruptions along multiple nerves (multidermatomal) that are resistant to treatment.
 4. Progressive viral brain destruction known as multifocal leukoencephalopathy.
 5. Hepatitis, as described under the criteria in Listing 5.05 (Chapter 20).
- Ⓔ Cancer:
1. Carcinoma of the cervix, invasive, FIGO stage II and beyond.
 2. Kaposi's sarcoma with:
 - a. Extensive oral lesions, or
 - b. Involvement of the gastrointestinal tract, lungs or other large internal (visceral) organs, or
 - c. Involvement of the skin or mucous membranes, as described under the criteria in 14.08Ⓔ.
 3. Lymphoma (for example, primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease).
 4. Squamous cell carcinoma of the anus.
- Ⓕ Conditions of the skin or mucous membranes (other than described in parts Ⓓ2, Ⓓ2 or Ⓓ3, above) with extensive fungating or ulcerating lesions not responding to treatment. Examples of qualifying conditions are eczema or psoriasis, vulvovaginal candidiasis or other mucosal candida, venereal warts on the genitalia (condyloma) caused by human papillomavirus and ulcerative diseases of the genitalia. Or, if more appropriate, the lesions can be evaluated under the criteria of the listings dealing with skin disorders (listings with an 8 prefix, Chapter 23).
- Ⓖ Blood (hematologic) abnormalities:
1. Decreased red blood cells (anemia), as described under the criteria in Listing 7.02 (Chapter 22).
 2. Decreased white blood cells (granulocytopenia), as described under the criteria in Listing 7.15 (Chapter 22).
 3. Decreased platelets (thrombocytopenia), as described under the criteria in Listing 7.06 (Chapter 22).
- Ⓗ Neurological abnormalities:
1. Encephalopathy caused by HIV, characterized by thinking (cognitive) or movement abnormalities (motor dysfunction) that limit function and progressively worsen.
 2. Other neurological manifestations of HIV infection such as nerve damage (peripheral neuropathy) as described under the criteria in the listings dealing with nervous system disorders (listings with an 11 prefix, Chapter 26).
- Ⓖ HIV wasting syndrome, characterized by involuntary weight loss of 10% or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, either:
1. Chronic diarrhea with two or more loose stools daily, lasting for one month or longer, or
 2. Chronic weakness and documented fever greater than 38° C (100.4° F) for the majority of one month or longer.
- Ⓖ Diarrhea, lasting for one month or longer, resistant to treatment, and requiring intravenous fluids (hydration), intravenous feeding (alimentation) or tube feeding.
- Ⓖ Cardiomyopathy, as described under the criteria in the listings dealing with heart disease (listings with a 4 prefix, Chapter 19) or the neurological listing dealing with strokes (11.04, Chapter 26).
- Ⓖ Nephropathy, as described under the criteria in the listings dealing with kidney disease (listings with a 6 prefix, Chapter 21).
- Ⓖ One or more of the following infections (other than described in parts Ⓐ through Ⓖ, above), resistant to treatment or requiring hospitalization or intravenous treatment three or more times in one year. Or evaluate abnormalities caused by the infection (sequelae) under the criteria for the affected body system, including:
- infection affecting the whole body (sepsis)
 - infection of the meninges covering the brain or spinal cord (meningitis)
 - infection of the lungs (pneumonia)
 - infection of a joint (septic arthritis)
 - infection of the heart (endocarditis)
 - infection of a sinus (sinusitis) documented by x-rays.

Ⓝ Repeated manifestations of HIV infection. These manifestations can include those listed in parts Ⓐ through Ⓜ that don't have findings required by those parts of the listing—for example, carcinoma of the cervix not meeting the criteria in part Ⓔ, or diarrhea not meeting the criteria in part Ⓜ. Other manifestations of HIV infection can also be considered, such as white lesions on the sides of the tongue (oral hairy leukoplakia), or muscle inflammation (myositis). Whatever the manifestation, it must result in significant, documented symptoms or signs (for example, fatigue, fever, malaise, weight loss, pain, night sweats) and one of the following at the marked level of severity:

- restriction of activities of daily living
- difficulties in maintaining social functioning, or
- difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence or pace.

j. Residual Functional Capacity

Medical judgment must be applied to individual cases, taking into account residual impairment from both the HIV-associated disorders and treatment given. Additionally, reference should be made to comments about RFCs under other listings as appropriate to the types of problems related to the HIV infection. Particular attention should be paid to whether the person has the strength to stand and walk six to eight hours a day. If not, the RFC cannot be higher than sedentary work. Especially in people over 50 years of age, allowance on a medical-vocational basis becomes much more likely with a sedentary RFC. (Refer to Chapter 9 for a detailed discussion of medical-vocational rules.)

14. Listing 114.08: Human Immunodeficiency Virus (HIV) Infection (Children)

SSA policies on HIV infections in children and adults have many similarities. But there are enough differences that a separate discussion is necessary.

a. General

See “General” in Listing 14.08 above.

b. Definitions

See “Definitions” in Listing 14.08 above.

c. HIV Infection in Children

The clinical manifestation and course of disease in children who become infected with HIV at or near the time of birth

(perinatally) or in the first six years of life may differ from that in older children and adults. In addition, survival times are shorter for children infected in the first year of life compared to those who become infected as older children or as adults. Infants may fail to gain weight (failure to thrive) or develop pneumocystis carinii pneumonia (PCP). Young children may have recurrent infections, neurological problems or developmental abnormalities. Older children may also exhibit neurological abnormalities, such as HIV brain damage (encephalopathy), or failure to thrive.

The methods of identifying and evaluating neurological abnormalities may vary depending on a child's age. For example, in an infant, impaired brain growth can be documented by a decrease in the growth rate of the head. In older children, impaired brain growth can be documented by brain atrophy on a CAT scan. Neurological abnormalities can also be observed in a younger child by the loss of previously acquired, or marked delays in achieving developmental milestones. In an older child, this type of neurological abnormality would generally be demonstrated by the loss of previously acquired intellectual abilities. Although loss of previously acquired intellectual abilities can be documented by a decrease in intelligence quotient (IQ) scores or demonstrated if a child forgets information he or she previously learned, it can also be shown if the child is unable to learn new information. This could include the sudden acquisition of a new learning disability.

Children with HIV infection may contract any of a broad range of bacterial infections. Certain major infections caused by pyogenic (pus-forming) bacteria—for example, some pneumonias—can be severely limiting, especially in pre-adolescent children. These major bacterial infections should be evaluated under part Ⓐ5, which requires two or more such infections within a two-year period. Although part Ⓐ5 applies only to children younger than 13 years of age, an older child may be found to have an impairment of equivalent severity if the circumstances of the case warrant (for example, delayed puberty).

Otherwise, bacterial infections are evaluated under part Ⓐ6. The criteria of the listing are met if one or more bacterial infections occurs and requires hospitalization or intravenous antibiotic treatment three or more times in one year. Pelvic inflammatory disease in older female children should be evaluated under multiple or recurrent bacterial infections in part Ⓐ6.

d. Evaluation of HIV Infection in Children

The criteria in this listing do not describe the full spectrum of diseases or conditions manifested by individuals with HIV infection. As in any case, consideration must be given

to whether a child's impairment meets or equals in severity any other listing (for example, the cancer listings with the prefix 113, Chapter 28). Although this listing includes cross-references to other listings for the more common manifestations of HIV infection, other additional listings may also apply.

In addition, the effect of all impairments on a claimant, whether or not related to HIV infection, must be considered. Individuals with HIV infection may manifest signs and symptoms of a mental impairment (for example, anxiety or depression), or of another physical impairment. Medical evidence should include documentation of all physical and mental impairments, and the impairments should be evaluated not only under other listings mentioned in Listing 14.08, but under any other appropriate listings.

e. Documentation of HIV Infection in Children

The medical evidence must include documentation of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

i. Documentation of HIV Infection in Children by Definitive Diagnosis

A definitive diagnosis of HIV infection in children is documented by one or more of the following laboratory tests:

1. For a child 24 months of age or older, a serum specimen that contains HIV antibodies. HIV antibodies are usually detected by a screening test. The most commonly used screening test is the ELISA. Although this test is highly sensitive, it may yield false positive results. Therefore, positive results from an ELISA must be confirmed by a more definitive test, such as the Western blot or immunofluorescence assay (IFA).
2. A specimen that contains immune-reactive parts of the human immunodeficiency virus (HIV antigen), such as serum specimens, lymphocyte cultures or cerebrospinal fluid (CSF) specimens.
3. Other tests that are highly specific for detection of HIV, such as polymerase chain reaction (PCR), or that are acceptable methods of detection consistent with the prevailing state of medical knowledge.

ii. Other Acceptable Documentation of HIV Infection in Children

HIV infection cannot be documented in children younger than 24 months of age by a serum specimen containing HIV antibodies. This is because women with HIV infection often transfer HIV antibodies to their newborns. The mother's

antibodies can persist in the infant for up to 24 months, even if the infant is not HIV-infected. Only 20% to 30% of such infants with HIV antibodies are actually infected. However, the presence of HIV antibodies accompanied by evidence of significantly depressed T-helper lymphocytes (CD4), an abnormal CD4/CD8 ratio or abnormal immunoglobulin G (IgG) may be used to document HIV infection in a child under 24 months of age, even though such testing is not a basis for a definitive diagnosis. Immunoglobulin G is an antibody produced in response to HIV infection. The helper/suppressor ratio is the number of helper lymphocytes (CD4 lymphocytes) divided by the number of suppressor lymphocytes (CD8 lymphocytes). An abnormally low CD4/CD8 ratio suggests that CD4 lymphocytes are being destroyed.

For children from birth to 24 months of age who have tested positive for HIV antibodies, HIV infection may be documented by one or more of the following:

1. For an infant 12 months of age or less, a CD4 (T4) count of $1,500/\text{mm}^3$ or less, or a CD4 count less than or equal to 20% of total lymphocytes.
2. For an infant from 12 to 24 months of age, a CD4 (T4) count of $750/\text{mm}^3$ or less, or a CD4 count less than or equal to 20% of total lymphocytes.
3. An abnormal CD4/CD8 ratio.
4. An IgG significantly greater than or less than the normal range for age.

HIV infection may also be documented without the definitive laboratory tests described above, if such documentation is consistent with the prevailing state of medical knowledge and clinical practice and with the other evidence. If no definitive laboratory evidence is available, HIV infection may be documented by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence.

For example, a diagnosis of HIV infection will be accepted without definitive laboratory evidence of HIV infection if the claimant has an opportunistic disease, such as toxoplasmosis of the brain or pneumocystis carinii pneumonia (PCP). Toxoplasmosis and PCP are caused by protozoan organisms that only seriously infect people with weak immune systems. Their presence strongly suggests that the child has a defect in cell-mediated immunity caused by a low CD4 lymphocyte count. However, to reach this conclusion without definitive laboratory evidence of HIV infection, there must be no other known cause of diminished resistance to the opportunistic disease concerned. For instance, long-term steroid treatment and lymphoma-type cancer can also suppress the immune system. In all cases without definitive laboratory evidence of HIV infection, the SSA must make every reasonable effort to obtain full details of the history, medical findings and results of testing.

f. Documentation of Manifestations of HIV Infection

A person with HIV infection does not necessarily have symptoms, much less opportunistic diseases or other functional limitations. Therefore, the medical evidence must also include documentation of any possibly disabling manifestations of HIV infection. Such manifestations could include, for example, opportunistic infections such as pneumocystis carinii pneumonia, or cancer. Such manifestations would justify a diagnosis of AIDS. However, the listing itself does not mention AIDS because it is the severity of the impairments that matters and not whether there is a diagnosis of AIDS. A treating doctor cannot establish severity on the basis of an AIDS diagnosis. Documentation of manifestations of HIV infection may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

i. Documentation of Manifestations of HIV Infection in Children by Definitive Diagnosis

The definitive method of diagnosing opportunistic diseases or conditions that are manifestations of HIV infection is by culture, serological test or microscopic examination of biopsied tissue or other material (for example, bronchial washings). Therefore, the SSA must make every reasonable effort to obtain specific laboratory evidence of an opportunistic disease or other condition whenever this information is available. If a test of tissue (histological test) or other test has been performed, the evidence should include a copy of the appropriate report. If the report is not obtainable, the summary of hospitalization or a report from the treating source should include details of the findings and results of the diagnostic studies (including x-ray reports) or microscopic examination of the appropriate tissues or body fluids.

Although a reduced CD4 lymphocyte count may show that there is an increased susceptibility to opportunistic infections and diseases, that alone does not establish the presence, severity or functional effects of a manifestation of HIV infection in a child.

ii. Other Acceptable Documentation of the Manifestations of HIV Infection in Children

Manifestations of HIV infection may also be documented without the definitive laboratory evidence described in section a, above, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, manifestations of HIV infection may be documented by medical history, clinical and laboratory findings and diag-

noses indicated in the medical evidence. In such cases, every reasonable effort must be made to obtain full details of the history, medical findings and results of testing.

Documentation of cytomegalovirus (CMV) disease (part ⑩) presents special problems because diagnosis requires identification of viral inclusion bodies or a positive culture from the affected organ, and the absence of any other infectious agent. A positive serology test identifies infection with the virus, but does not confirm a disease process. With the exception of chorioretinitis (which may be diagnosed by an ophthalmologist), documentation of CMV disease requires confirmation by biopsy or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

g. Effect of Treatment

Medical treatment must be considered in terms of its effectiveness in decreasing the signs, symptoms and laboratory abnormalities of the specific disorder, or of the HIV infection itself. For example, the antiretroviral drugs used to treat HIV and AIDS may have side effects of treatment that may further impair a claimant.

Response to treatment and adverse or beneficial consequences of treatment may vary widely. For example, a child with HIV infection who develops a middle ear infection (otitis media) may respond to the same antibiotic regimen used in treating children without HIV infection, but another child with HIV infection may not respond to the same regimen. Therefore, each case must be considered on an individual basis, along with the effects of treatment on the child's ability to function.

A specific description of the drugs or treatment given (including surgery), their dosage, frequency of administration, and a description of the complications or response to treatment should be obtained. The effects of treatment may be temporary or long-term. As such, the decision regarding the impact of treatment should be based on a sufficient period of treatment to permit proper consideration.

h. Functional Criteria

Part ⑩ of this listing establishes standards for evaluating manifestations of HIV infection that do not meet the requirements listed in parts ① through ⑨. Part ⑩ is applicable for manifestations that are not listed in parts ① through ⑨, as well as those that are listed in parts ① through ⑨ but do not meet the criteria of any of the rules in parts A through ⑨.

For children with HIV infection evaluated under part ⑩, listing-level severity will be assessed in terms of the functional limitations imposed by the impairment. The full impact of

signs, symptoms and laboratory findings on the child's ability to function must be considered. Important factors to be considered in evaluating the functioning of children with HIV infection include—but are not limited to:

- symptoms, such as fatigue and pain
- characteristics of the illness, such as the frequency and duration of manifestations or periods of worsening and improvement (exacerbation and remission) in the disease course, and
- the functional impact of treatment for the disease, including the side effects of medication.

To meet the criteria in part ⑩, a child with HIV infection must demonstrate a level of restriction in either one or two (depending on the child's age) of the general areas of functioning applicable to the child's age group.

i. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child must have a diagnosis of human immunodeficiency virus (HIV) infection and part ①, ②, ③, ④, ⑤, ⑥, ⑦, ⑧, ⑨, ⑪, ⑫, ⑬, ⑭, ⑮ or ⑯, below.

① Bacterial infections:

1. Mycobacterial infection such as tuberculosis (TB) or related infections (for example, caused by *M. avium-intracellulare*, *M. kansasii*) at a site other than the lungs, skin or cervical or hilar lymph nodes. Also, pulmonary tuberculosis resistant to treatment qualifies under this part of the listing.
2. Nocardiosis.
3. Salmonella bacteria in the blood (bacteremia), recurrent non-typhoid type.
4. Syphilis (evaluate under the criteria for the affected body system, such as the listings dealing with vision (listings with a 2 prefix, Chapter 17), heart or blood vessels (listings with a 4 prefix, Chapter 19) or the nervous system (listings with an 11 prefix, Chapter 26).
5. In a child younger than 13 years of age, multiple or recurrent pus-forming bacterial infections (pyogenic bacterial infections) of the following types: sepsis, pneumonia, meningitis, bone or joint infection or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses) occurring two or more times in two years.
6. Multiple or recurrent bacterial infections, including infections of the female reproductive organs (pelvic inflammatory disease), requiring hospitalization or intravenous antibiotic treatment three or more times in one year.

② Fungal infections:

1. Aspergillosis.
2. Candidiasis, at a site other than the skin, urinary tract or intestinal tract. Also, candidiasis at a site other than the mucous membranes of the mouth, vulva or vagina. Candidiasis involving the esophagus, trachea, bronchi or lungs qualifies under this part of the listing.
3. Coccidioidomycosis, at a site other than the lungs or lymph nodes.
4. Cryptococcosis, at a site other than the lungs (for example, cryptococcal meningitis).
5. Histoplasmosis, at a site other than the lungs or lymph nodes.
6. Mucormycosis.

③ Protozoan or parasitic worm (helminthic) infections:

1. Cryptosporidiosis, isosporiasis or microsporidiosis protozoan infections, with diarrhea lasting for one month or longer.
2. *Pneumocystis carinii* pneumonia or pneumocystis carinii infection occurring outside of the lungs.
3. Strongyloidiasis parasitic worm infection occurring outside of the intestines.
4. Toxoplasmosis protozoan infection of an organ other than the liver, spleen or lymph nodes.

④ Viral infections:

1. Cytomegalovirus disease at a site other than the liver, spleen or lymph nodes.
2. Herpes simplex virus causing:
 - a. Skin or mucous membrane infection affecting the mouth, genitals or perianal region, lasting for one month or longer or
 - b. Infection at a site other than the skin or mucous membranes (for example, bronchitis, pneumonitis, esophagitis or encephalitis), or
 - c. Infection that has spread widely throughout the body (disseminated infection).
3. Herpes zoster, either disseminated or with eruptions along multiple nerves (multi-dermatomal) that are resistant to treatment.
4. Progressive viral brain destruction known as multifocal leukoencephalopathy.
5. Liver inflammation (hepatitis), as described under the criteria in Listing 105.05 (Chapter 20).

⑤ Cancer:

1. Carcinoma of the cervix, invasive, FIGO stage II and beyond.
2. Kaposi's sarcoma with:
 - a. Extensive oral lesions, or
 - b. Involvement of the gastrointestinal tract, lungs or other large internal (visceral) organs, or
 - c. Involvement of the skin or mucous membranes, as described under the criteria in part ⑥.

3. Lymphoma (for example, primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma or Hodgkin's disease).
 4. Squamous cell carcinoma of the anus.
- Ⓔ Conditions of the skin or mucous membranes (other than described in parts Ⓒ2, Ⓓ2 or Ⓓ3, above) with extensive fungating or ulcerating lesions not responding to treatment. Examples of qualifying conditions are eczema or psoriasis, vulvovaginal candidiasis or other mucosal candida, venereal warts on the genitalia (condyloma) caused by human papillomavirus and ulcerative diseases of the genitalia. Or, if more appropriate, the lesions can be evaluated under the criteria of the listings dealing with skin disorders (listings with an 8 prefix, Chapter 23).
- Ⓕ Blood (hematologic) abnormalities:
1. Decreased red blood cells (anemia), as described under the criteria in Listing 7.02 (Chapter 22).
 2. Decreased white blood cells (granulocytopenia), as described under the criteria in Listing 7.15 (Chapter 22).
 3. Decreased platelets (thrombocytopenia), as described under the criteria in Listing 107.06 or 7.06 (Chapter 22).
- Ⓖ Neurological manifestations of HIV infection such as brain damage (HIV encephalopathy) or nerve damage (peripheral neuropathy), as described under the criteria in the nervous system listings (listings with a 111 prefix, Chapter 26), or resulting in one or more of the following:
1. Loss of previously acquired, or marked delay in achieving, developmental milestones or intellectual ability (including the sudden acquisition of a new learning disability).
 2. Decreased brain growth, as demonstrated by a cessation of head growth (acquired microcephaly) or by brain atrophy.
 3. Progressive movement abnormalities (motor dysfunction) resulting in:
 - significantly decreased ability to stand (station) and walk (gait), or
 - significantly decreased ability to make large (gross) and small (dexterous) movements with the fingers.
- Ⓗ Growth disturbance, with:
1. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall of 15 percentiles from established growth curve (on standard growth charts) that persists for two months or longer.
 2. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall to below the third percentile from established growth curve (on standard growth charts) that persists for two months or longer.
 3. Involuntary weight loss greater than 10% of baseline that persists for two months or longer.
 4. Decreased growth as described under the criteria in growth impairment listings (listings with a 100 prefix, Chapter 16).
- Ⓙ Diarrhea, lasting for one month or longer, resistant to treatment and requiring intravenous fluids (hydration), intravenous feeding (alimentation) or tube feeding.
- Ⓚ Cardiomyopathy, as described under the criteria in the listings dealing with heart disease (listings with a 104 prefix, Chapter 19) or the neurological listing dealing with strokes in adults (11.04, Chapter 26).
- Ⓛ Lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia (LIP/PLH complex), with respiratory symptoms that significantly interfere with age-appropriate activities, and that cannot be controlled by prescribed treatment.
- Ⓜ Nephropathy as described under the criteria in the listings for kidney disease (listings with a 106 prefix, Chapter 21).
- Ⓝ One or more of the following infections (other than described in parts Ⓐ through Ⓛ, above), resistant to treatment or requiring hospitalization or intravenous treatment three or more times in one year. Or evaluate abnormalities caused by the infection (sequelae) under the criteria for the affected body system, including:
1. Infection affecting the whole body (sepsis).
 2. Infection of the meninges covering the brain or spinal cord (meningitis).
 3. Infection of the lungs (pneumonia).
 4. Infection of a joint (septic arthritis).
 5. Infection of the heart (endocarditis).
 6. Infection of a sinus (sinusitis) documented by x-rays.
- Ⓞ Any other manifestations of HIV infection. Such manifestations can include those listed in parts Ⓐ through Ⓝ that don't have findings required by those parts of the listing—for example, oral candidiasis not meeting the criteria in part Ⓔ, or diarrhea not meeting the criteria in part Ⓙ. Also, other manifestations of HIV infection can be considered, such as white lesions on the sides of the tongue (oral hairy leukoplakia) or an enlarged liver (hepatomegaly). Whatever the manifestation, it must result in one of the following:
1. For children from birth to attainment of age one, at least one of the criteria in parts Ⓐ through Ⓔ of Listing 112.12.
 2. For children age one to attainment of age three, at least one of the appropriate age-group criteria in part Ⓖ1 of Listing 112.02.
 3. For children age three to attainment of age 18, at least two of the appropriate age-group criteria in part Ⓖ2 of Listing 112.02.

15. Listing 14.09: Inflammatory Arthritis (Adults)

Rheumatoid or inflammatory arthritis is a disease of the immune system that causes inflammation: tenderness, swelling and pain in the tissues surrounding the joints (see general discussion in Section A, above). The cause of the inflammation does not matter, and inflammation caused by other conditions, for example psoriasis, can also qualify a person under this listing. Both rheumatoid and psoriatic arthritis most often affect the small joints of the hands. Rheumatoid arthritis (RA) is the most common inflammatory joint disorder seen by the SSA.

Your joints may be red, warm and swollen as a result of inflammation. You may suffer stiffness of joints, joint effusions, weight loss or fever, but none of these are specifically required by the listing.

For purposes of the following discussion, the term “major joints” refers to the major peripheral joints, which are the hip, knee, shoulder, elbow, wrist/hand, and ankle/foot.

a. Listing Level Severity

For your condition to be severe enough to meet this listing, your condition must satisfy A, B, C, D or E, below.

A You must have a history of joint pain, swelling and tenderness. Also, on current physical examination, you must show signs of joint inflammation or deformity in two or more major joints, making you either unable to walk effectively or unable to perform fine and gross movements effectively.

Part A can be satisfied by ineffective use of either the upper or lower extremities as follows.

Walking: Extreme limitation in your ability to walk means you must be unable to sustain a reasonable walking pace over a sufficient distance to be able to carry out your activities of daily living. You would not have the ability to travel without a companion’s assistance to and from a place of employment or school. More specifically, some examples of ineffective ambulation given by the SSA include:

- inability to walk without the use of a walker
- inability to walk without the use of two crutches or two canes
- inability to walk a block at a reasonable pace on rough or uneven surfaces
- inability to use standard public transportation
- inability to carry out ordinary activities involving walking, such as shopping and banking, or
- inability to climb a few steps at a reasonable pace with the use of a single hand rail.

The listing does not require you to be completely unable to walk in all circumstances. For example, your ability to walk about your home without someone else’s help or the use of assistive devices does not, in and of itself, mean you cannot qualify under the listing. To qualify, you must have serious difficulty in starting, sustaining, or completing activities. Also understand that the use of only one crutch or cane would not necessarily restrict you from qualifying under the listing, provided that your functional limitations are severe enough. In addition, the SSA recognizes that people who cannot walk effectively might be able to stand without assistive devices. Therefore, your ability to stand without assistance would not disqualify you under the listing.

Performance of fine and gross movements: To use your upper extremities effectively in carrying out your activities of daily living, you must be able to perform such functions as reaching, pushing, pulling, grasping, and fingering. Examples of being unable to effectively perform fine and gross movements include, but are not limited to, being unable to prepare a simple meal and feed yourself, to take care of personal hygiene, to sort and handle papers or files or to place files in a file cabinet at or above waist level.



To qualify under part A, it is not necessary that you have a *total* inability to use your upper extremities. You must, however, have serious difficulty in starting, sustaining, or completing activities.

B Ankylosing spondylitis or other spondyloarthropathy.

This diagnosis must be established by findings of unilateral or bilateral sacroiliitis, as demonstrated by the presence of erosion or fusion (ankylosis) of your sacroiliac joints. These abnormalities must show up on imaging tests such as plain x-rays, an MRI scan or a CT scan.

Additionally, part B requires you to have both 1 and 2, below.

1. A history of back pain, tenderness, and stiffness.
2. Findings on physical examination of ankylosis (fixation) of your dorsolumbar or cervical spine at 45 degrees or more of flexion measured from the vertical position (zero degrees).

Note that to satisfy part B, you don’t have to be relying on an assistive device like a cane in order to walk. A person with the symptoms and other findings in part B has their gaze fixed downward at a sharp angle, which produces extreme functional limitation by restricting vision ahead, above and to the side. Walking will be extremely limited, so it is not necessary for the SSA to spell out that fact under part B.

Ⓒ An impairment as described under the criteria in Listing 14.02Ⓐ.

Ⓓ Inflammatory arthritis, with signs of peripheral joint inflammation on current examination. However, you can have less joint involvement than in part Ⓐ and fewer extra-articular features than in part Ⓒ.

Additionally, part Ⓓ requires you to have both 1 and 2, below:

1. Significant, documented constitutional symptoms and signs (e.g., fatigue, fever, malaise, weight loss).
2. Involvement of two or more organs/body systems. At least one of the organs/body systems must be involved to at least a moderate level of severity. Moderate means more than slight or mild, as a matter of medical judgment.

Ⓔ Inflammatory spondylitis of any cause. Your deformity can be less than in part Ⓓ, and you don't have to have extra-articular abnormalities so severe that they satisfy some other listing as required in part Ⓒ. However, you must have signs of sacroiliitis in at least one sacroiliac joint and the extra-articular features described in 14.09Ⓓ 1 and 2.

b. Residual Functional Capacity

Upper Extremity Dysfunction: The SSA needs information regarding how well you can use your upper extremities—specifically, the extent of your ability to push, pull, lift, carry and grasp objects and do small movements with your fingers (fine manipulations). Think of all the things you cannot do because of pain, deformity or fatigue. Can you pick up coins? Easily grasp and turn doorknobs? Open jars? If you were unable to perform prior work because of arthritis, exactly how did the arthritis interfere? Specific examples of why you can no longer perform the job are much better than vague generalizations such as, “I was in pain” or “My arthritis bothered me.” For instance, how much weight can you lift and carry? Did your pain limit your use of hand controls that were necessary for you to work? Exactly how? Include environmental factors; for example, arthritis that is tolerable working in normal temperatures might be limiting in the cold. If you have significant arthritis in your shoulder, pain will probably limit the amount of overhead work you can do. Shoulder, elbow, or hand arthritis will limit how much pushing and pulling you can do.

Note that the use of an assistive device such as a cane ties up the use of an arm and hand. So if you require a cane to walk, the SSA cannot refer you to jobs requiring you to lift and carry with both arms while walking.

Lower Extremity Dysfunction: In evaluating your RFC, the SSA must determine how long you can stand and walk on arthritic joints. Let the SSA know if the arthritis is severe enough that you can't stand or walk for most of a workday; have your treating doctor provide supportive statements. For the SSA to claim that you can perform light, medium or heavy work, you must be able to walk or stand six to eight hours a day. Significant arthritis in a major joint of a lower extremity would prevent such standing or walking. Even if your hands and arms are unaffected by the arthritis, you'll be restricted to sedentary work. If you are older and have a limited education, these restrictions may mean that you'll be awarded benefits on the basis of your RFC.

If you had an arthritic hip, knee or ankle joint replaced with an artificial one, see the RFC comments under Listing 1.03.

Other Functional Limitations: The limitations you face due to the involvement of organs other than your joints must be evaluated on a case-by-case basis. If your back is involved, it is extremely important to document your limitations in bending, sitting, standing, and walking. Also, back pain and back stiffness can be pointed out as separate limitations.

16. Listing 114.09: Inflammatory Arthritis (Children)

See comments under adult Listing 14.09.

a. Listing Level Severity

For the child's condition to be severe enough to meet this listing, the child's condition must satisfy Ⓐ, Ⓑ, Ⓒ, Ⓓ or Ⓔ, below.

Ⓐ The child must have a history of joint pain, swelling and tenderness. A current physical examination must reveal signs of joint inflammation or deformity in two or more major joints. This inflammation or deformity must result in the child being unable to walk effectively or perform fine and gross movements.

Walking: For children who are too young to be expected to walk independently, the SSA considers their function in terms of how well they can perform age-appropriate activities with their lower extremities. For such children, an extreme level of limitation means skills or performance at no greater than one-half of age-appropriate expectations based on an overall developmental assessment rather than on one or two isolated skills.

Older children who qualify would not have the ability to travel without a companion's assistance to and from a place of employment or school. More specifically, some examples of ineffective ambulation given by the SSA include the child's:

- inability to walk without the use of a walker
- inability to walk without the use of two crutches or two canes
- inability to walk a block at a reasonable, age-appropriate pace on rough or uneven surfaces
- inability to use standard public transportation
- inability to carry out ordinary age-appropriate activities involving walking, such as shopping and school activities, or
- inability to climb a few steps at a reasonable pace with the use of a single hand rail.

The listing does not require that the child be completely unable to walk in all circumstances. For example, the child's ability to walk around the house (or short distances at school) without someone else's help or the use of assistive devices does not, in and of itself, mean the child cannot qualify under the listing. The listing requires that the child have serious difficulty in starting, sustaining, or completing activities. Also understand that the use of only one crutch or cane would not necessarily restrict the child from qualifying under the listing, provided that the child's functional limitations are severe enough. In addition, the SSA recognizes that people who cannot walk effectively might be able to stand without assistive devices. Therefore, the child's ability to stand without assistance would not disqualify her under the listing.

Performance of fine and gross movements: In cases of very young children, SSA looks at the limitations in the child's ability to perform age-appropriate activities involving the upper extremities. To determine whether such children have an extreme limitation, see the limitations for persistent motor dysfunction for infants and young children described in Listing 110.07A.

For an older child to use her upper extremities effectively in carrying out age-appropriate activities of daily living, she must be able to perform age-appropriate functions like reaching, pushing, pulling, grasping, and fingering. Therefore, in older children, examples of inability to effectively perform fine and gross movements include being to prepare a simple meal and feed themselves, to take care of personal hygiene or to sort and handle papers or files (depending on which activities are

age-appropriate). To qualify under part ④, it is not necessary that the child be *totally* unable to use her upper extremities. The requirement is that she have serious difficulty in starting, sustaining, or completing age-appropriate activities.

- ⑤ Ankylosing spondylitis or other spondyloarthropathy. This diagnosis must be established by findings of unilateral or bilateral sacroiliitis, as shown by erosion or fusion (ankylosis) of the sacroiliac joints. These abnormalities must appear on imaging tests such as plain x-rays, an MRI scan or a CT scan.

Additionally, part ⑤ requires the child to have both 1 and 2, below.

1. A history of back pain, tenderness, and stiffness.
2. Findings on physical examination of ankylosis (fixation) of the dorsolumbar or cervical spine at 45 degrees or more of flexion measured from the vertical position (zero degrees).

Note that to satisfy part ⑤, the child need not require an assistive device like a cane in order to walk. A person with the symptoms and other findings in part ⑤ has their gaze fixed downward at a sharp angle, which produces extreme functional limitation by restricting vision ahead, above and to the side. Walking will be extremely limited, so it is not necessary for the SSA to spell out that fact under part ⑤.

- ⑥ An impairment as described under the criteria in Listing 114.02A.
- ⑦ Inflammatory arthritis, with signs of peripheral joint inflammation on current examination. However, the child can have less joint involvement than in part ④ and fewer extra-articular features than in part ⑥.

Additionally, part ⑦ requires that the child have both 1 and 2, below:

1. Significant, documented constitutional symptoms and signs (such as fatigue, fever, malaise or weight loss).
2. Involvement of two or more organs/body systems. At least one of the organs/body systems must be involved to at least a moderate level of severity. Moderate means more than slight or mild, as a matter of medical judgment.

- ⑧ Inflammatory spondylitis of any cause. The child can have lesser deformity than in part ⑤, and doesn't have to have extra-articular abnormalities so severe that the child satisfies some other listing as required in part ⑥. However, the child must show signs of sacroiliitis in at least one sacroiliac joint as well as the extra-articular features described in 14.09⑦ 1 and 2. ■

Appendix A

Glossary of Bureaucratic Terms

Adjudication: The process of determining a disability claim.

Adjudicator: A person officially involved in making the disability determination.

Administrative law judge (ALJ): An SSA employee and attorney who holds hearings at the first level of appeals above the state agency (DDS).

Allegations: The medical problems that a claimant puts forth as his or her basis for wanting disability benefits.

Alleged onset date (AOD): The date a claimant states that he or she became unable to work due to impairments.

Claimant: The person who applies for disability benefits.

Closed period: If an impairment does not qualify as severe enough for benefits at the time of adjudication, benefits can still be given for prior periods of at least 12 months during which there was sufficient severity.

Concurrent claims: Two claims filed at the same time, under different aspects of the law. Usually, concurrent claims are a Title 2 and SSI/Title 16 claim filed at the same time.

Consultative examination (CE): Physical or mental examination of a claimant at the expense of the SSA.

Consultative examination (CE) doctor: A doctor or other health professional paid by the SSA to perform a consultative examination. See *Consultative Examination*.

Continuing disability review (CDR): The process by which the SSA reevaluates the severity of a

claimant's impairments to determine whether there has been significant medical improvement.

diary: A term which has two meanings:

1. The interval of time until a claim is reevaluated after benefits are allowed, and
2. The interval of time a State agency holds a claim to determine the outcome of some medical problem or treatment, before a final determination is made. When a claim is held to determine an outcome, the State agency will send the claimant a letter informing him that a final decision has been delayed for a specified amount of time, usually not more than three months.

Disability determination: The determination that an adult is unable to work and qualifies for benefits or, that a child qualifies for benefits.

Disability Determination for Social Security Administration (DDS-SSA) or Disability Determination Services (DDS): A state agency. See *State agency*.

Disability hearing officer (DHO): An experienced disability examiner who interviews claimants receiving disability payments to determine if benefits should continue. Claimants appear before a DHO when they are about to lose disability benefits to appeal the termination of benefits.

Duration: How long a claimant has had an impairment severe enough to qualify for Social Security disability benefits.

Equal: Allowance term meaning that a claimant has an impairment as severe as required by the listings, although no specific listing exactly applies to their claim. The equal concept can be applied to single

or multiple listings, as well as single or multiple impairments, as appropriate to a particular claim.

Examiner: The DDS examiner is specially trained to make initial, reconsideration and continuing disability review determinations regarding nonmedical evidence from a claimant's file. Examiners physically control individual claimant files that are assigned to them, as well as communicate with claimants or their representatives. (See Chapter 5.)

Impairments: The medical problems that a claimant has, either mental or physical.

Initial claim: The first application for disability benefits.

Listings: Lists of rules giving the medical criteria that must be fulfilled for benefits to be granted without consideration of age, education or work experience. Separate listings exist for adults and children. Listings are found in the *Listing of Impairments* in federal regulations (Code of Federal Regulations, Title 20, Part 404, Subpart P, Appendix 1, and reinterpreted in Chapters 16 through 29 of this book).

Medical consultant (MC): A medical doctor, osteopath or psychologist who works under contract or as an employee of a State agency (DDS), or who works in some similar role in some other level of the SSA. The SSA may refer to those evaluating mental disorders as *psychological consultants*. The MC is specially trained by the SSA and other MCs to make the "overall determination of impairment severity" in initial, reconsideration and continuing disability review determinations. This determination must be done according to federal rules, regulations and other written guidelines based on the medical and nonmedical evidence. All medical evidence used in these determinations is obtained from medical and other sources outside of the state agency. MC determinations should not be biased, and therefore the MCs do not meet, talk to or treat claimants concerning their individual claims. Medical consultants are not the same as doctors who do consultative examinations. Consultative examination doctors examine claimants for a fee paid by the SSA. Unlike medical consultants, they do not make disability determinations.

Medical-vocational allowance: Allowance of disability benefits based on a combination of RFC, age, education and work experience.

Meet: Allowance term meaning that a claimant's impairment exactly fulfills the requirements of a listing.

Not severe (nonsevere): Term that means all impairments considered together are still not sufficient to produce any significant restriction in the functional capacity of a claimant. A mild or slight impairment.

Onset: The date at which a claimant's impairments are sufficiently severe to qualify for disability. This is not necessarily the same as the date when the impairment first arose.

Presumptive disability: A privilege of SSI/Title 16 claimants in which they can receive benefits (and sometimes Medicaid) for up to six months before a final decision is made on their claim by a state agency. SSDI/Title 2 claimants cannot have presumptive disability.

Projected rating: The opinion of the SSA about the level of residual impairment severity that is expected to exist 12 months after the onset of allowance level severity. Allowance level severity must persist 12 months before benefits are granted. Such a projected rating could result in either allowance or denial, depending on medical or vocational factors. If a projected rating is a denial it is a way of saying that while an impairment may be severe enough to be disabling at the present time, it is expected to improve to nonallowance severity in less than 12 months.

Reconsideration claim: A denial of benefits or an unfavorable decision made by a DDS that is being reconsidered at the request of the claimant. Reconsideration is not automatic; a claimant must request it.

Residual functional capacity (RFC): A claimant's maximum mental or physical capabilities as determined by a DDS medical consultant in instances in which the impairment does not meet or equal a listing, but is more than "not severe" (slight). See *Medical consultant*.

State agency: One of the agencies in each state funded by the Social Security Administration to make decisions on disability claims. The examiners and other administrative personnel are state employees, even though they're funded with federal dollars. Also known as Disability Determination Service (DDS).

Substantial gainful activity (SGA): Making too much money through work to be eligible for disability benefits. Blind claimants can make more than non-blind claimants. The amount that you can earn without losing benefits is increased yearly.

Treating doctor: Any medical doctor or psychologist who treats a claimant at his own request and is not paid by the SSA. A claimant's treating doctor can also be his CE Doctor, if the treating doctor has agreed with the SSA to do such exams. See *Consultative examination*. According to federal regulations,

your treating doctor is not involved in making disability determinations.

Trial work period (TWP): An interval of time for claimants already on the disability rolls in which they can work and continue to draw benefits, until it is clear they can actually perform a job well enough to take care of themselves.

Vocational analyst: In the DDS, an experienced disability examiner with special training in evaluating the combination of RFC, age, education and work experience regarding a claimant's ability to perform various jobs. ■

Appendix B

Examples of Technical Rationales for Denials

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We have included this appendix of technical rationales for denials to give you added insight into how and why the Social Security Administration issues denials in specific cases. In the following examples, the doctor and hospital names and dates have been removed or changed. Names and dates must, however, be listed in actual notice rationales. If the DDS fails to list some of your important medical sources, you can assume that they were not used in your disability determination. This can be the basis for an appeal.

Form SSA-4268 Denials from Initial Application

Example 1: Impairment(s) Not Severe

The only source of medical evidence provided by the claimant was the Mercy Hospital outpatient treatment report. Since this report was incidental to the claimant's alleged impairments and no other medical evidence existed, two CEs were arranged: one to evaluate the claimant's general health; the other to assess the possibility of organic brain damage due to apparent alcohol abuse. The claimant alleges disability since January 2, 20xx, due to "bad lungs, high blood pressure and forgetfulness." There is no indication that the claimant has worked since that date.

A review of the Mercy Hospital report indicates the claimant was treated for a bruised arm. An x-ray was taken due to complaints of pain in her arm. The x-ray was negative. She was treated for abrasions and released within hours of admittance.

Dr. Meyer's report notes the claimant alleged constant fatigue and an inability to remember recent events. She admitted to drinking about two six-packs of beer every day and to smoking one to two packs of cigarettes daily for at least three years. Medical examination shows the claimant's height as 66 inches and her weight as 140 pounds. Her blood pressure is 124/85 repeated; pulse 76 and regular. Some increased A/P [anterior-posterior or front to back] diameter of the chest, distant breath sounds and scattered rhonchi [a type of abnormal breathing sound heard through a stethoscope] are noted. The chest x-ray is consistent with chronic obstructive pulmonary disease (COPD) with somewhat flattened diaphragms. No infiltrates

are noted. PFTs [pulmonary function tests] were obtained and show FEV1 [forced expiratory volume in 1 second] of 1.6 liters and MVV [maximum voluntary ventilation] of 75 L/min, both recorded after inhaled bronchodilators. The EKG [electrocardiogram] is normal as is the neurologic examination. Extremities show no muscle wasting or weakness. Slight hepatomegaly [enlarged liver] is noted; however, LFTs [liver function tests] are normal with the exception of an elevated SGOT [a liver enzyme] of 75 units. The CBC [complete blood count] is normal with the exception of a MCV [mean corpuscular volume] of 110.

Analysis of findings based on the above medical summation shows the claimant's breathing capacity, as evidenced by PFT values, is not significantly diminished. In addition, despite some liver enlargement and elevated SGOT, other liver studies were normal. The neurological system was essentially intact and blood pressure was within normal limits. Consequently, no impairment related to these findings exists since they are essentially normal.

To assess the possibility of organic brain syndrome, the claimant was referred to Dr. Johnson. His assessment includes use of a WAIS [Wechsler Adult Intelligence Scale], the Wechsler Memory Scale and the Bender-Gestalt. No indication of memory loss or psychosis is shown to exist. The claimant tested to be above average intellectually with a full scale IQ of 110.

Dr. Johnson's report indicates the claimant admitted to drinking to steady her nerves, but she did not report any disorder of thought or constriction of interest. She appeared to have good personal habits. According to Dr. Johnson's report and the report by the DO [District Office, same as Field Office], her daily activities are not restricted. She does not appear withdrawn or isolated. She helps her mother take care of the house and does the shopping.

The above medical summary indicates the claimant's mental functional restrictions are present only during acute intoxication. The claimant has above normal intellect, and normal memory and thought processes. She does not behave bizarrely. There is no indication she cannot understand and follow directions. Appropriate daily activities show there is no significant restriction of work-related functions. There is no evidence that the individual cannot perform basic work-related functions on a sustained, longitudinal basis.

For an impairment to be considered severe, it must significantly limit the individual's physical or mental abilities to do basic work activities. Medical evidence does not demonstrate an impairment that is severe nor does the combined impact of respiratory, liver, and psychiatric impairments produce a severe impairment. Accordingly, the claimant is found not disabled because she has no severe impairment, nor any combination of impairments that is severe.

Example 2: Can Perform Past Work

The claimant has said that he became unable to work as of 06/15/20xx due to "a heart condition." He was in the hospital when he applied and was to have bypass surgery. There is no work issue.

The medical evidence documents the presence of coronary artery disease. The claimant was hospitalized 06/22/20xx due to chest pain with EKG changes suggestive of ischemia. Cardiac catheterization showed 75% obstruction of the left main coronary artery. He was discharged to await bypass surgery. Triple bypass surgery was performed 07/09/20xx. Three months after surgery, the treating physician reported that there was no chest pain. No treadmill test had been done and none was planned. The doctor said the claimant should limit lifting to 10–20 pounds.

The evidence documents the presence of a severe cardiovascular impairment. However, the findings do not meet or equal the severity of any of the listed impairments. While Listing 4.04©.1.b was met at the time of the angiogram, the bypass surgery improved the condition and there is no longer any chest pain. The claimant would be restricted from lifting more than ten pounds frequently or more than 20 pounds occasionally due to his heart condition. There are no other medically imposed limitations or restrictions. The individual is capable of performing light work.

After a military career that ended in 1986, the claimant did no work until 01/93 when he was employed as a cashier in a discount liquor house. This was full-time work at SGA [substantial gainful activity] levels until 01/95. From 01/95 until AOD [alleged onset date] 6/15/20xx, he worked on weekends only, and that work was not SGA. The period 01/93–01/95 lies within the relevant 15-year period, and was of sufficient duration for him to gain the job experience necessary

for average job performance. Therefore, his job as cashier has current relevance.

Demands of the job included sitting most of the day while operating a cash register, observing the merchandise being purchased, taking the customers' money and making change. These duties entailed the abilities to sit, see, talk, reach, handle, finger and feel. He also demonstrated an elementary knowledge of mathematics and cash register function. It was occasionally necessary for him to stand and walk a few feet to secure a register tape, and then insert the tape into the machine.

With the exertional capacity to do light work, and, in the absence of any nonexertional limitations, this individual is able to do his past relevant work as he described it. Therefore, he is not disabled.

Example 3: Can Perform Other Work

The claimant has alleged disability since 5/1/20xx due to "diabetic, hearing, heart." When he has diabetic attacks, he has cold sweats, shakes and acts drunk. He has no chest pain. The DO claims representative noted that he had a hearing aid and occasionally needed questions repeated. The claimant is not engaging in any work activity.

Medical evidence reveals the presence of insulin-dependent diabetes. There are allegations of frequent diabetic attacks, but there are no medical records to support this. A general consultative examination was obtained, as there was insufficient evidence from the treating source to evaluate severity. This revealed the following abnormal findings. Corrected vision was 20/25 with grade one over four diabetic changes of the fundi [retinas]. He wore a hearing aid and had difficulty hearing a tuning fork. Pulses were two plus over four. The lower extremities showed some mild chronic venous insufficiency but no varicose veins. There was no evidence of diabetic neuropathy. No heart problem was documented. There is x-ray evidence of an abdominal aortic aneurysm. This is asymptomatic and surgery is not anticipated. There is no complaint of chest pain. A consultative hearing evaluation was done since further documentation of severity was needed. The audiogram showed bilateral hearing loss between 65 to 85 decibels. Speech discrimination is 88 percent and a hearing aid is recommended and

used by the claimant. He can hear loud conversational speech and can hear over the phone.

None of the above impairments is of the severity described in the Listing of Impairments. The combination of impairments also does not meet or equal the listed impairments.

The evidence reveals the presence of diabetes, and aortic aneurysm, and a hearing deficit. Per SSA-4734-F4, dated September 10, 1984, heavy lifting would be precluded due to the aneurysm. The claimant can lift and carry 25 pounds frequently and up to 50 pounds occasionally. The hearing deficit and alleged insulin reactions would preclude work around dangerous machinery or at heights.

The claimant is 60 years old and has completed nine years of school, which is considered to be limited education. He has worked for 34 years as a wire drawer for a wire company.

This heavy, semiskilled work performed in a noisy and hazardous work setting required him to be on his feet all day, frequently lift 50 pounds coils of wire, and occasionally lift coils which weigh 100 pounds. It also required frequent pushing, pulling, stooping, crouching, reaching, handling and fingering for purposes of situating the coils on the wire-drawing machine and drawing the desired finished product. The claimant set up the machine, demonstrated knowledge of the characteristics of various metals and assessed conformance to specifications. Demands of his past relevant work correlate to those of Wire Drawer (wire), DOT 614.382-010 [job description in the *Dictionary of Occupational Titles*].

The claimant's exertional limitations in themselves as translated into a maximum sustained RFC for medium work would prevent him from doing his past relevant work. The special medical-vocational characteristics pertaining to those cases which feature arduous, unskilled work or no work are not present. The exertional capability to do medium work presents a potential occupational base of approximately 2,500 unskilled sedentary, light and medium occupations, which represent a significant vocational opportunity. This individual's hearing impairment and the medical restriction to avoid working around dangerous machinery and at heights would only minimally narrow that potential occupational base; age, education and past work experience under the framework provided

by [medical-vocational] rule 203.04, he is expected to effectuate a vocational accommodation to other work.

Some examples of unskilled occupations which are within his RFC include: Bagger (ret. tr.), DOT 920.687-014, Turner (can. & preserv.), DOT 522.687-038, and Crate Line (furn.), DOT 920.687-078. According to data shown in County Business Patterns for 1982, Harris County, Texas, had over 230,000 employees working in the retail trade industry; over 30,000 of which were employed in grocery stores. Both the furniture manufacturing and wholesale furniture industries combined employed over 5,000 individuals. Another 200-500 worked at canning and preserving fruits and vegetables. Based on these figures, which pertain only to one county, it can be inferred reasonably that the cited occupations exist as individual jobs in significant numbers not only in the region in which the individual resides, but also throughout the national economy.

Therefore, since he has the capacity to do other work, disability is not established.



More technical rationales from real Forms SSA-4268 are below. These are from decisions to end benefits following a CDR and illustrate the many reasons benefits may be terminated. Again, explanations of abbreviations and medical terms have been added in brackets so the rationales are a little easier to follow.

Form SSA-4268 Denials From Continuing Disability Review (CDR)

Example 1: Not Severe, MI [Medical Improvement] Occurred

The beneficiary was found to be disabled beginning 8/10/97, because of a fractured left femur with slow healing. The impairment met the requirements of Listing 1.11. Current evaluation is necessary since medical improvement was expected. He indicates that he is still unable to perform work activity due to a left leg problem. He has not engaged in any substantial gainful activity since onset.

Current medical evidence reveals that the disabled individual had full weight-bearing status at an examination in February 1999. X-rays interpreted at that time revealed that the fracture was well healed. A consultative orthopedic evaluation was secured since

range-of-motion data were needed. The consulting orthopedic surgeon reported that the individual had good range of motion of both lower extremities. He walked with a normal gait and experienced no difficulty in getting on and off the examining table. His impairment does not meet or equal listing severity.

At the CPD [comparison point decision] the individual was unable to walk without crutches and x-rays did not show the expected amount of healing. His impairment has decreased in severity since he is fully weight-bearing and an x-ray shows solid union; therefore, medical improvement has occurred. Since the beneficiary met a listing at the CPD but currently no longer meets that listing, the medical improvement is related to the ability to work. Although he alleges a left leg problem, his current impairment is not severe as he now has no significant restrictions on standing, walking, lifting or other work activities.

As medical improvement has occurred and the individual is able to engage in SGA, disability ceases April 1999 and benefits will terminate in June 1999.

Example 2: MI Occurred, Can Perform Past Work

This individual was found to be disabled beginning 8/17/95 because of coronary artery disease. The impairment equaled Listing 4.04¹. The beneficiary has completed a nine-month trial work period. She continues to work as a telephone solicitor with earnings indicative of SGA. Benefits have been stopped as indicated on SSA-833-U5 or 11/13/98. She feels she still has a severe heart condition which limits activity. A current medical decision is needed to determine "impairment severity" and thus, entitlement for an extended period of eligibility.

Medical evidence indicates that the beneficiary underwent bypass surgery in June 1996. Although she initially progressed well, she subsequently began to complain of chest pain and shortness of breath. She underwent a second bypass surgery in April 1997. Current examination revealed normal heart sounds with only occasional premature ventricular contractions. The beneficiary experiences chest pain infrequently with heavy exertion. The pain is relieved with nitroglycerin or rest. The doctor stated that the patient would not be able to return to work activity. The treating cardiologist reported in March 1999 that the beneficiary performed a stress test to 7 METS [metabolic equivalents]. A chest x-

ray revealed only mild cardiomegaly. She assessed that because of the beneficiary's history of heart disorder, she should avoid lifting in excess of 25 pounds.

The record reveals that the patient underwent two bypass surgeries for her heart disorder. Chest pain of cardiac origin is experienced infrequently, but a treadmill exercise test was negative at 5 METS. It showed abnormalities at 7 METS. Therefore, the evidence does not show current findings that meet or equal the listed impairments. The second bypass surgery improved circulation to the heart and symptoms have decreased. Therefore, medical improvement has occurred.

At the time of the CPD, a listing was equaled. Since the impairment no longer meets or equals that listing, the medical improvement is related to the ability to work.

The record reveals that the beneficiary continues to have a severe cardiovascular impairment that limits her ability to perform basic work activities. There is a current capacity to lift a maximum of 20 pounds occasionally and 10 pounds frequently.

The beneficiary is limited to light work activity. Her past work from 3/90 to 8/95 was that of a laundry marker, which involved such activities as sorting laundry, putting names on articles, etc. This is a light, nonstressful job. Accordingly, she can return to her past relevant work as she has the functional capacity to do light work.

Although the beneficiary's treating physician stated she would not be able to return to work, the weight to be given such statements depends upon the extent to which they are supported by specific and complete clinical findings and are consistent with other evidence in the beneficiary's case. The clinical findings and other evidence do not support the conclusion that the beneficiary is disabled for any gainful work.

Since medical improvement has been demonstrated by a decrease in medical severity related to the ability to work and since the beneficiary is able to engage in SGA, impairment severity ceases in 3/99.

Example 3: MI Occurred, Can Do Other Work

The beneficiary has been disabled since 2/6/96 because of musculoskeletal injuries sustained in a motorcycle accident. He was found to be limited to sedentary work and [Medical-] Vocational Rule 201.09 directed a finding of disabled. He has not worked

since his established onset date. The beneficiary alleges he remains unable to return to any work activity because he still has knee pain. Current evaluation is needed because medical improvement was expected.

The treating physician reported that he continued treating the beneficiary for complaints of pain to the lower extremities. He states that he treated the beneficiary with medication and advised him to exercise. X-rays taken at the examination on 1/8/99 revealed only spurring in the right knee in addition to old healed fractures. A consultative examination was arranged to obtain range of motion. Evidence from the consulting orthopedist dated 3/1/99 reveals that the beneficiary continues to walk with an abnormal gait. Flexion of the right knee is limited to 120 degrees. The left can be fully flexed. Range of motion of the hips and ankles is normal. The impairment does not meet or equal the requirements of the Listings.

At the comparison point, the beneficiary was unable to ambulate for short distances as a result of his right knee impairment. X-rays revealed that all other injuries were healed except the right knee, which did not have complete healing. Current medical evidence demonstrates a decrease in severity since an x-ray revealed that the right knee fracture is well healed with minimal spurring and there is only mild limitation of motion. Therefore, medical improvement has occurred as there is a decrease in medical severity. He now has the ability to stand and walk 6 out of 8 hours and to lift 20 pounds occasionally and 10 pounds frequently which is a wide range of light work. The medical improvement that has occurred is related to his ability to work, since he could only do sedentary work activity at the CPD. The beneficiary's impairment imposes significant restrictions on his ability to perform basic work activities and is severe.

Although the beneficiary alleges pain in the right knee, the fracture is well-healed with minimal spurring and mild limitation of motion. He is restricted to light work but the clinical findings do not establish an impairment which produces pain of such severity as to prevent the beneficiary from performing any gainful activity.

The disabled individual is 53 years of age, has a limited education, and has a 20-year work history as a general laborer in a foundry which is unskilled work involving heavy lifting and carrying. Since the benefi-

ciary is limited to light work, he would be unable to perform his past work due to the exertional demands involved. The special medical-vocational characteristics pertaining to those cases which feature arduous, unskilled work or no work are not present. The facts in this case correspond exactly with the criteria of [Medical-] Vocational Rule 202.10 which directs a finding of not disabled. Since there is medical improvement and the individual has the ability to do SGA, disability is ceased in 2/99 and benefits will be terminated as of 4/99.

Example 4: MI Occurred, Multiple Not Severe Impairments; Combined Effect Is Severe, but One Impairment Is a Subsequent Impairment; Can Perform Other Work

The beneficiary has been under a disability since 10/19/93 due to rheumatic heart disease with mitral stenosis [narrowing of the mitral heart valve] and peptic ulcer [of intestine] which led to an allowance in the framework of [Medical-] Vocational Rule 202.10. The case is being evaluated now as medical improvement is possible. The beneficiary believes he is still disabled because of his heart condition plus recent pulmonary disease. He attempted working a few years ago but had to stop after three weeks. There is no SGA issue.

Medical evidence reveals a history of rheumatic heart disease which required hospitalization for congestive heart failure. This has responded to treatment and currently there is no chest pain and no evidence of pulmonary or peripheral edema, according to his physician. There are no symptoms related to peptic ulcer disease since diet has been adjusted. Recently, shortness of breath has been increasing. He had been smoking two packs of cigarettes a day for 20 years but has stopped because of respiratory problems. A consultative examination was scheduled for evaluation of his respiratory impairment with pulmonary function testing.

On physical examination, height was 69" and weight was 180 lbs. Breath sounds were diminished with prolonged expiration and an expiratory wheeze. The chest was otherwise clear. On examination of the heart, a diastolic rumble [abnormal heart sound] at the apex. An EKG showed a prominent wide P-wave suggestive of left atrial enlargement, which was

confirmed on the chest x-ray. The heart size otherwise was within normal limits. The lung fields were hyperaerated [over-expanded] and diaphragms were somewhat flattened [signs of emphysema]. Ventilatory function [breathing test] studies done by the consultant revealed post-bronchodilator [drugs] FEV1 was 1.9 liters and MVV 76 liters per minute [abnormally low results indicate emphysema, but not at listing level severity].

Current medical findings do not meet or equal the findings described in any listed impairment. There is no current evidence of congestive heart failure and no active ulcer. This shows medical improvement as there is a decrease in the medical severity of impairments present at the CPD. At that time the functional capacity was for light work activity. The current RFC, considering only the rheumatic heart disease and peptic ulcer, shows full capacity to do all work activities and these impairments are now not severe. Therefore, medical improvement related to ability to do work is demonstrated.

Although the heart and digestive impairments are not severe when considered alone, considering their effect on ability to perform work activities in combination with a respiratory impairment, the beneficiary would be restricted to lifting up to 50 lbs. occasionally and 25 lbs. frequently. The beneficiary now has the capacity to perform a full range of medium work. He cannot perform his prior work as baker helper (heavy, unskilled work). It involved much lifting of things, such as bags of flour (up to 100 pounds), racks of baked items and piles of unfolded boxes. Although his most recent work was arduous and unskilled, it lasted only 17 years and he previously did semiskilled work. Therefore, the special medical-vocational characteristics pertaining to those cases, which feature arduous, unskilled work or no work, are not present. He is of advanced age (56) with limited education (grade 6) and meets [Medical-] Vocational Rule 203.11 which indicates the ability to do SGA. Since there is medical improvement, demonstrated by decreased medical severity and related to the ability to work, and the individual has the ability to do SGA, disability is ceased on 4/99. Benefits will be terminated 6/99.

Example 5: MI Occurred; It Is Obvious That the Vocational Exception Also Applies, Can Perform Other Work

The beneficiary was initially allowed disability benefits from 12/7/96, because of injuries received in a motor-cycle accident. At the time of the CPD, he had a traumatic left above the knee amputation with persistent stump complications, inability to use a prosthesis, and a right recurrent shoulder dislocation. The impairment was found to meet Listing 1.10@3. The current evaluation is necessary as medical improvement was expected. The beneficiary states that he is still disabled because of a left leg amputation and difficulty walking with his prosthesis. He has not worked since the onset date.

The medical evidence reveals that following his left above the knee amputation in 12/96 the beneficiary experienced persistent pain and tenderness about the stump and underwent three stump revisions. The most recent revision was 2/1/98 for excision of a bony spur and painful scar. Office notes from the beneficiary's treating physician show that following the latest stump revision the beneficiary was able to wear his prosthesis over an extended period of time without much discomfort. Recent examination of the stump revealed that there were no neuromas [painful nerve tangles] or other abnormalities. An x-ray did not demonstrate any bony spurs or complications. Furthermore, the beneficiary has had no recent problems with right shoulder dislocation. He had full range of motion of his shoulder without pain or instability. The beneficiary no longer has an impairment which meets or equals the level of severity described in the listings.

The beneficiary was unable to use his prosthesis at the time of the comparison point decision because of repeated stump complications. Current medical findings show that these complications have resolved and the beneficiary is able to ambulate with his prosthesis over an extended period of time without discomfort. Therefore, medical improvement has occurred. Although he alleges difficulty walking with his prosthesis, the beneficiary has the residual functional capacity to stand and walk for two hours and to sit for six hours with no further restrictions. Since his current condition no longer meets or equals Listing 1.10@3, his medical improvement is related to the ability to work.

The beneficiary received evaluation and counseling through the Department of Vocational Rehabilitation. He obtained funds to attend a two year program at Central University. In December 1998 he received an associate degree in computer science. The combination of education and counseling constitute vocational therapy.

The beneficiary has a severe impairment which limits him to the performance of sedentary work. The beneficiary is 30 years old with 16 years of education. He has four years of relevant work experience as a painter. This job involved standing and walking at least 6 out of 8 hours. The beneficiary is unable to perform his past work because of limitations on standing and walking. The special medical-vocational characteristics pertaining to those cases which feature arduous, unskilled work or no work are not present. Additionally, his ability to perform sedentary work has been enhanced by vocational therapy; therefore, the vocational therapy exception applies. The beneficiary meets [Medical-] Vocational Rule 201.28 which directs a decision of not disabled. Medical improvement is established, the vocational therapy exception applies and the beneficiary is able to engage in SGA. Therefore, the beneficiary can no longer be considered disabled under the provisions of the Social Security Act as of May 1999 and benefits are terminated as of July 1999.

Example 6: MI Is Not Related to Ability to Do Work, but Vocational Therapy Exception Applies, Can Perform Other Work

The beneficiary was found to be disabled beginning 8/3/96 as a result of a crush injury with fracture of his left ankle. He was restricted to the performance of light work and thereby met the requirements of [Medical-] Vocational Rule 202.06 which directed a decision of disabled. Current medical evidence was obtained because medical improvement was expected. The beneficiary states that he continues to be disabled because of left ankle pain and difficulty standing and walking. He has not worked since onset of his disability.

Recent medical information from the beneficiary's physician shows that the beneficiary continues to have pain and numbness in his left foot. An ankle fusion was done 9/98 to provide a stable joint and to permit weight bearing. He is fully weight-bearing

now, but walks with a prominent limp. In order to further document severity and obtain a current x-ray, the beneficiary was examined by a consulting orthopedic physician. Clinical examination of the left ankle revealed some thickening of the heel but the fusion appeared to be stable. Ankle movements are limited to 10 degrees dorsiflexion [upward movement] and 20 degrees plantar-flexion [downward movement]. An x-ray was consistent with a healed subtalar arthrodesis [surgical ankle fusion] and moderate traumatic degenerative changes. Neurological evaluation revealed an absent left ankle jerk and inability to walk on heels and toes. There was decreased sensation over the lateral and dorsal [upper] aspects of the left foot and decreased strength of the left extensor hallucis longus [muscle that moves the great toe upward].

The beneficiary's impairments do not meet or equal the level of severity described in the listings. An x-ray shows that arthritis has developed at the fracture site. The beneficiary continues to experience left ankle pain. Further, he has an abnormal gait and limitation of motion of his ankle. However, since the ankle fusion the beneficiary has full weight-bearing, which is medical improvement since the CPD. His left ankle impairment continues to restrict his ability to stand and walk to 6 hours during an 8-hour day. The beneficiary remains limited to the performance of a wide range of light work, lifting 20 lbs. occasionally and 10 lbs. frequently. This is the same RFC as that at the CPD. Therefore, the medical improvement is not related to his ability to work.

Since the comparison point decision, the beneficiary underwent vocational counseling through the Department of Rehabilitation Services and enrolled in an 18-month training program on small appliance repair. He completed the course on 11/30/98 after working on appliances such as radios, electrical tools and a variety of small household appliances.

The recent completion of this specialized training course in conjunction with counseling constitutes vocational therapy. This therapy has enhanced the beneficiary's ability to perform work since he has acquired a skill which provides for direct entry into light work.

Although the beneficiary continues to experience left ankle pain, he is fully weight-bearing and is able to perform light work. The clinical findings do not

establish an impairment which results in pain of such severity as to preclude him from engaging in any substantial gainful activity.

The beneficiary has a severe impairment which restricts him to light work. He is 57 years old with 12 years of education. He has 6 years of relevant work experience as a truck driver which is a medium semi-skilled job. The beneficiary is unable to perform work as a truck driver because of the exertional demands of the job and there are no transferable skills. The special medical-vocational characteristics pertaining to those cases which feature arduous, unskilled work or no work are not present. However, as a result of vocational therapy since the comparison point decision, the beneficiary has obtained job skills which are useful in the performance of light work and, therefore, meets [Medical-] Vocational Rule 202.08 which directs a decision of not disabled. He can do such occupations as an Electrical-Appliance Repairer (DOT 723.381-010), a Radio Repairer (DOT 720.281-010) or as an Electrical Tool Repairer (DOT 729.281-022), all skilled light work in the electrical equipment industry. According to the Labor Market Trends Bulletin and the Virginia Department of Labor and Industry, over 30,000 individuals are employed in the electrical equipment industry in Virginia; and the cited occupations are well represented throughout that industry. It can be inferred that the occupations exist as individual jobs in significant numbers in the region where the individual lives and throughout the national economy.

While there has been no medical improvement related to the ability to work in the beneficiary's impairment, the vocational therapy exception to medical improvement applies and the beneficiary is able to engage in SGA. The beneficiary is no longer disabled as of 3/99 and benefits are terminated as of 5/99.

Example 7: No MI, Not Severe Impairment(s), but Error Exception Applies

The beneficiary was initially allowed disability benefits from 6/21/92 because of chronic obstructive pulmonary disease and asthma. She was restricted to light work and [Medical-] Vocational Rule 202.09 was applied. Current findings were obtained because medical improvement is possible. The beneficiary alleges that she is still unable to work because of emphysema and has not worked since her onset.

A report from the beneficiary's treating physician states that the beneficiary has chronic obstructive pulmonary disease and complains of shortness of breath. She also has been diagnosed as having asthma, allergic sinusitis and hay fever. These conditions are controlled with medications. A consultative exam was necessary to obtain ventilatory studies. A chest x-ray revealed mild chronic obstructive pulmonary disease. Pulmonary function studies [4/2/99] showed FEV1, of 1.7 and MVV of 75. A physical exam showed a height of 5 feet 2 inches and weight 120 lbs. There were decreased breath sounds; otherwise, the chest was clear [normal] to percussion [thumping] and auscultation [listening]. The impairment does not meet or equal the level of severity described in the listings.

The beneficiary was receiving treatment for asthma and COPD at the comparison point. She was hospitalized in October 1979 for an asthma attack. Ventilatory studies done during the admission showed a functional restriction to light work and the claim was allowed using a [medical-] vocational rule. Review of the records demonstrates that the studies were done while the beneficiary was in acute phase of asthma. Wheezes and rales [abnormal breath sounds] were noted and no bronchodilator [drug] was administered prior to testing. Documentation guidelines in effect at the CPD prohibit the use of ventilatory studies performed in the presence of bronchospasm [narrowed airways]. Out-patient records sent later as trailer material reveal that ventilatory testing was repeated in December, 1992. These studies show an FEV1 of 1.9 and MVV of 84. Medical improvement has not occurred [because there is no significant difference between the 12/92 and 4/99 breathing test results]. However, the error exception applies since the beneficiary was allowed using ventilatory studies performed in the presence of bronchospasm without the administration of bronchodilators and additional evidence which relates to the CPD shows that if that evidence had been considered in making the CPD, disability would not have been established.

The beneficiary does not have any restrictions on standing, walking, or lifting as a result of her breathing impairment and her impairment is not severe. Therefore, the beneficiary retains the capacity to do SGA.

The error exception of the MIRS applies, and the beneficiary has the ability to perform SGA. Disability ceases April 1999 and benefits will terminate as of June 1999.

Example 8: Failure to Cooperate

The beneficiary has been under a disability since 4/13/93 due to histiocytic lymphoma of the ileum [lymph node cancer affecting the third part of the small intestine] which equaled the listing. Current evaluation is necessary as medical improvement is possible. There has been no work since onset. The beneficiary says he is still disabled because of stomach problems. He had chemotherapy and radiation therapy after his operation. Because he has ulcers, he must avoid certain foods.

The only treatment source given by the beneficiary was Wadsworth Memorial Hospital. The Oncology [cancer] Clinic notes indicate he had completed chemotherapy. He was last seen 12/8/97 at which time he was progressing satisfactorily. He weighed 170 pounds with height of 6 feet. Lymph nodes were shotty [small and hard, like shot] and the liver was enlarged. Since no current medical evidence was available, a consultative examination was scheduled for February 10, 1999.

The beneficiary failed to keep the consultative examination. He was contacted and another appointment was scheduled which he again failed to keep.

On 3/1/99 personal contact was made by the District Office at the beneficiary's home. The need for current medical evidence and for his cooperation in going for a CE was explained. There was no indication of any mental impairment or other condition that would make him unable to cooperate. Since he agreed to keep a CE, another appointment was scheduled for 3/9/99. The beneficiary did not keep the CE and the DDS was unable to contact him by telephone. On 3/15/99 written notice that failure to cooperate could result in termination was sent to the beneficiary. He did not respond.

At the CPD, the beneficiary had malignant lymphoma of the ileum with metastasis. The most recent available evidence from 12/8/97 indicates satisfactory progress. There is no current medical evidence available to determine if medical improvement has occurred and the beneficiary has repeatedly failed to cooperate in efforts to obtain current medical evidence. Therefore, since there is failure to cooperate, a group II exception to medical improvement, disability is ceased 3/99, the month the beneficiary was notified that failure to cooperate could result in termination of benefits. Disability will terminate 5/99. ■

Appendix C

Medical-Vocational Rules

If you are not eligible for disability based solely on your illness or injury, the Social Security Administration looks at other issues to determine if you meet eligibility requirements in some other way.

The following tables of medical-vocational rules are used by the SSA to decide whether physical impairment claims should be allowed or denied based on a combination of how much work you can do (called residual functional capacity, or RFC), age, education, and work experience. These rules are literally applied only in claims where the RFC is for sedentary, light, or medium work without other restrictions. If the RFC has additional special restrictions, then a vocational analyst may need to look at the claim. Other restrictions can include almost anything, such as inability of the claimant to work around excessive dust and fumes, inability to do fine movements with the fingers, inability to bend the back frequently, or inability to use leg controls.

In the Disability Determination Service (DDS), a vocational analyst is an experienced disability examiner with special training to evaluate the combination of RFC, age, education, and work experience in relation to a claimant's ability to perform various jobs. In these instances, the tables of medical-vocational rules are applied in a more flexible manner.

Claimants capable of heavy work can do such high levels of physical exertion that the SSA considers them

to have “not severe” (mild or slight) impairments, and so they do not actually receive RFC's for heavy work.

If your physical impairments are significant, but not severe enough to meet any listing, the medical-vocational rules will give you a good idea whether you are eligible for benefits at all. You already know your age, education, and work experience. You would have to either estimate the RFC yourself or find out from the SSA after a determination has been made on your claim.

The medical-vocational rules in these tables are only applied when the RFC is so physically restrictive that you cannot return to your prior work, if you had any. The medical-vocational rules help determine whether you could do any other kind of work. The rules are a consistent way for the SSA to determine disability. There are no similar medical-vocational rule tables for mental impairments.

If you *can* return to your prior work based on your RFC, there would be little point in looking at the medical-vocational rules—the SSA would simply deny your claim, stating that you can return to your prior work.

If you are fewer than six months away from your next birthday, your age will be counted as if you have reached that day. For example, if you are 49½ years old, the SSA will consider you 50 years old.

Review Chapter 8 (If You Can Do Some Work) and Chapter 9 (How Age, Education and Work Experience Matter) for information that will help you use these tables.



Medical-vocational rules are sometimes simply referred to as “vocational rules,” but this is inaccurate since each rule involves both medical and vocational factors.

Abbreviations

AA	advanced age (55–59 years old)
CAAA	closely approaching advanced age (50–54 years old)
CARA	closely approaching retirement age (60 or older)
YI	younger individual (less than 50 years old)
M	marginal education (6th grade or less)
LL	limited or less education (grades 7–11)
HSG	high school graduate or more (high school graduate, college graduate, or equivalent special training)
US	unskilled
SS	semiskilled
S	skilled
N	none
I	illiterate or unable to communicate in English

Table No. 1: Sedentary RFC

Rule	Age	Education	Previous Work Experience	Decision
201.01	AA	LL	US or N	Disabled
201.02	AA	LL	S or SS—skills not transferable	Disabled
201.03	AA	LL	S or SS—skills transferable	Not disabled
201.04	AA	HSG—education does not provide for direct entry into skilled work.	US or N	Disabled
201.05	AA	HSG—education provides for direct entry into skilled work.	US or N	Not disabled
201.06	AA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills not transferable	Disabled
201.07	AA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills transferable	Not disabled
201.08	AA	HSG—education provides for direct entry into skilled work.	S or SS—skills not transferable	Not disabled
201.09	CAAA	LL	US or N	Disabled
201.10	CAAA	LL	S or SS—skills not transferable	Disabled
201.11	CAAA	LL	S or SS—skills transferable	Not disabled
201.12	CAAA	HSG—education does not provide for direct entry into skilled work.	US or N	Disabled
201.13	CAAA	HSG—education provides for direct entry into skilled work.	US or N	Not disabled
201.14	CAAA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills not transferable	Disabled
201.15	CAAA	HSG—education does not provide for direct entry into skilled work	S or SS—skills transferable	Not disabled
201.16	CAAA	HSG—education provides for direct entry into skilled work	S or SS—skills not transferable	Not disabled
201.17	YI (45 - 49)	I	US or N	Disabled
201.18	YI (45 - 49)	LL	US or N	Not disabled
201.19	YI (45 - 49)	LL	S or SS—skills not transferable	Not disabled
201.20	YI (45 - 49)	LL	S or SS—skills transferable	Not disabled
201.21	YI (45 - 49)	HSG	S or SS—skills not transferable	Not disabled
201.22	YI (45 - 49)	HSG	S or SS—skills transferable	Not disabled
201.23	YI (18 - 44)	I	US or N	Not disabled
201.24	YI (18 - 44)	LL	US or N	Not disabled
201.25	YI (18 - 44)	LL	S or SS—skills not transferable	Not disabled
201.26	YI (18 - 44)	LL	S or SS—skills transferable	Not disabled
201.27	YI (18 - 44)	HSG	US or N	Not disabled
201.28	YI (18 - 44)	HSG	S or SS—skills not transferable	Not disabled
201.29	YI (18 - 44)	HSG	S or SS—skills transferable	Not disabled

Table No. 2: Light RFC

Rule	Age	Education	Previous Work Experience	Decision
202.01	AA	LL	US or N	Disabled
202.02	AA	LL	S or SS—skills not transferable	Disabled
202.03	AA	LL	S or SS—skills transferable	Not disabled
202.04	AA	HSG—education does not provide for direct entry into skilled work.	US or N	Disabled
202.05	AA	HSG—education provides for direct entry into skilled work.	US or N	Not disabled
202.06	AA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills not transferable	Disabled
202.07	AA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills transferable	Not disabled
202.08	AA	HSG—education provides for direct entry into skilled work.	S or SS—skills not transferable	Not disabled
202.09	CAAA	I	US or N	Disabled
202.10	CAAA	LL	US or N	Not disabled
202.11	CAAA	LL	S or SS—skills not transferable	Not disabled
202.12	CAAA	LL	S or SS—skills transferable	Not disabled
202.13	CAAA	HSG	US or N	Not disabled
202.14	CAAA	HSG	S or SS—skills not transferable	Not disabled
202.15	CAAA	HSG	S or SS—skills transferable	Not disabled
202.16	YI	I	US or N	Not disabled
202.17	YI	LL	US or N	Not disabled
202.18	YI	LL	S or SS—skills not transferable	Not disabled
202.19	YI	LL	S or SS—skills transferable	Not disabled
202.20	YI	HSG	US or N	Not disabled
202.21	YI	HSG	S or SS—skills not transferable	Not disabled
202.22	YI	HSG	S or SS—skills transferable	Not disabled

Table No. 3: Medium RFC

Rule	Age	Education	Previous Work Experience	Decision
203.01	CARA	M or N	US or N	Disabled
203.02	CARA	LL	N	Disabled
203.03	CARA	LL	US	Not disabled
203.04	CARA	LL	S or SS—skills not transferable	Not disabled
203.05	CARA	LL	S or SS—skills transferable	Not disabled
203.06	CARA	HSG	US or N	Not disabled
203.07	CARA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills not transferable	Not disabled
203.08	CARA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills transferable	Not disabled
203.09	CARA	HSG—education provides for direct entry into skilled work.	S or SS—skills not transferable	Not disabled
203.10	AA	LL	N	Disabled
203.11	AA	LL	US	Not disabled
203.12	AA	LL	S or SS—skills not transferable	Not disabled
203.13	AA	LL	S or SS—skills transferable	Not disabled
203.14	AA	HSG	US or N	Not disabled
203.15	AA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills not transferable	Not disabled
203.16	AA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills transferable	Not disabled
203.17	AA	HSG—education provides for direct entry into skilled work.	S or SS—skills not transferable	Not disabled
203.18	CAAA	LL	US or N	Not disabled
203.19	CAAA	LL	S or SS—skills not transferable	Not disabled
203.20	CAAA	LL	S or SS—skills transferable	Not disabled
203.21	CAAA	HSG	US or N	Not disabled
203.22	CAAA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills not transferable	Not disabled
203.23	CAAA	HSG—education does not provide for direct entry into skilled work.	S or SS—skills transferable	Not disabled
203.24	CAAA	HSG—education provides for direct entry into skilled work.	S or SS—skills not transferable	Not disabled
203.25	YI	LL	US or N	Not disabled
203.26	YI	LL	S or SS—skills not transferable	Not disabled

Table No. 3: Medium RFC (continued)

Rule	Age	Education	Previous Work Experience	Decision
203.27	YI	LL	S or SS—skills transferable	Not disabled
203.28	YI	HSG	US or N	Not disabled
203.29	YI	HSG—education does not provide for direct entry into skilled work.	S or SS—skills not transferable	Not disabled
203.30	YI	HSG—education does not provide for direct entry into skilled work.	S or SS—skills transferable	Not disabled
203.31	YI	HSG—education provides for direct entry into skilled work.	S or SS—skills not transferable	Not disabled

Appendix D

Benefits Planning Assistance and Outreach Programs

The following organizations are available to help you access work incentives planning and assistance services. Contact and service information are listed for every state, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands, American Samoa and the U.S. Virgin Islands.

Alabama

Mid Alabama Chapter of the Alabama
Coalition of Citizens with Disabilities
206 13th Street South
Birmingham, AL 35233
205-251-2223 x112

Alabama Department of Rehabilitation
Services
2129 East South Boulevard
Montgomery, AL 36111
800-441-7607

Alaska

University of Alaska
2210 Arca Drive
Anchorage, AK 99508
907-272-8270

American Samoa

Diverse Abilities
414 Kuwili Street, Suite 102
Honolulu, HI 96817
808-522-5400

Arizona

Arizona Bridge to Independent Living
(ABIL)
1229 E. Washington
Phoenix, AZ 85034
1-966-304-WORK (9675)

California

Center for Independence for the
Disabled
dba: Northern California Tri-County
BPAO Project
875 O'Neill Avenue
Belmont, CA 94002
650-595-0783

Center for Independent Living
dba: Beacon of Alameda County
2539 Telegraph Avenue
Berkeley, CA 94704
510-841-4776

Community Resources for
Independence, Inc.
dba: Back to Work Program
1040 N. State Street, Suite E
Ukiah, CA 95482
800-528-7704

Dayle McIntosh Center for the Disabled
13272 Garden Grove Blvd.
Garden Grove, CA 92843
714-621-3300

Disability Resources Agency for
Independent Living
221 McHenry Avenue
Modesto, CA 95354
209-521-7260

Disabled Resources Center
2750 E. Spring Street, Suite 100
Long Beach, CA 90806
562-427-1000 x111

Familia Unida
4716 East Cesar Chavez Avenue
Los Angeles, CA 90022
877-298-3267

Goodwill Industries of Southern
California
342 San Fernando Road
Los Angeles, CA 90031
323-223-1211 x2517

Independent Living Resource Center
423 West Victoria Street
Santa Barbara, CA 93101
805-963-0595

Independent Living Resource of Contra
Costa County
dba: Try Work!
3200 Clayton Road
Concord, CA 94519
925-363-7293

Legal Services of Northern California
dba: Work Incentives Education Project
604 12th Street
Sacramento, CA 95814
916-491-0515 or
800-655-6188

Project Independence
3505 Cadillac Ave., Suite P-101
Costa Mesa, CA 92626
619-561-8761

TODEC Legal Center Perris
dba: Partners for Success
234 South D Street
Perris, CA 92570
800-778-3713

Colorado

Cerebral Palsy of Colorado
2200 South Jasmine Street
Denver, CO 80222
877-772-2982

Delaware

United Cerebral Palsy of Delaware
700A River Road
Wilmington, DE 19809
302-698-9336

District of Columbia

Davis Memorial Goodwill Industries
2200 South Dakota Avenue, NE
Washington, DC 20018
202-636-4225

Florida

Abilities, Inc. of Florida
2735 Whitney Road
Clearwater, FL 33758
727-538-7370 x346

Brevard Achievement Center, Inc.
1845 Cogswell Street
Rockledge, Florida 32955
321-632-8610

Center for Independent Living
in Central Florida
720 N. Denning Drive
Winter Park, FL 32789
407-623-1070

Easter Seal Society of North Florida, Inc.
910 Myers Park Drive
Tallahassee, FL 32301
850-877-1021

Goodwill Industries of Central Florida
7531 South Orange Blossom Trail
Orlando, FL 32809
915-995-2106 x229

Goodwill Industries of North Florida, Inc.
4527 Lenox Avenue
Jacksonville, FL 32205
904-384-1361

Gulfstream Goodwill Industries, Inc.
1715 Tiffany Drive East
West Palm Beach, FL 33407
561-848-7200

Independent Living Resource Center of
NE Florida
2709 Art Museum Drive
Jacksonville, FL 32207
904-399-8484

Georgia

Division of Rehabilitation Services
1700 Century Circle, Suite 300
Atlanta, GA 30345
404-638-0382

Shepherd Center, Inc.
2020 Peachtree Street NW
Atlanta, GA 30309
404-350-7589

Walton Options for Independent Living
948 Walton Way
P.O. 519
Augusta, GA 30903
706-724-6262

Guam

Diverse Abilities
414 Kuwili Street, Suite 102
Honolulu, HI 96817
808-522-5400

Hawaii

Diverse Abilities
414 Kuwili Street, Suite 102
Honolulu, HI 96817
808-522-5400

Idaho

Idaho Division of Vocational
Rehabilitation
650 West State St., Room 150
PO Box 83720
Boise, ID 83720
208-334-3390

Illinois

Mayor's Office
City of Chicago
2102 West Ogden Avenue
Chicago, IL 60612
312-746-5743

Department of Human Services,
Mental Health
160 N. LaSalle Street, 10th Floor
Chicago, IL 60601
312-814-7196

Illinois Department of Human Services
623 East Adams
P.O. Box 19429
Springfield, IL 62704
800-807-6962
866-444-8013 TTY

Indiana

The Center for Mental Health
1100 Broadway
Anderson, IN 46015
765-641-8382

Trustees of Indiana University
P.O. Box 1847
Bloomington, IN 47402
812-855-6508

Iowa

Black Hawk Center for Independent
Living
312 Jefferson Street
Waterloo, IA 50701
319-291-7755

Kansas

Cerebral Palsy Research Foundation
5111 East 21st Street
Wichita, KS 67208
316-688-1888

Kentucky

Center for Accessible Living, Inc.
981 South 3rd Street, Suite 102
Louisville, KY 40203
502-589-6620

Independence Place, Inc.
153 Patchen Drive, Suite 33
Lexington, KY 40517
859-266-2807

Louisiana

LSU Health Sciences Center
433 Bolivar Street, 8th Floor
New Orleans, LA 70112
504-942-8240

Office of the Governor
State of Louisiana
P.O. Box 94004
Baton Rouge, LA 70804
225-219-7547

Maine

Maine Medical Center
22 Bramhall Street
Portland, ME 04102
207-871-2088

Maryland

Independence NOW, Inc.
6811 Kenilworth Avenue, #504
Riverdale, MD 20737
301-277-2839

MCIL Resources for Independent Living
5807 Harford Road
Baltimore, MD 21214
410-444-1400

Massachusetts

Massachusetts Rehabilitation Commission
27 Wormwood Street
Boston, MA 02210
617-204-3854

Massachusetts Project With Industry
251 West Central Street, Suite 31
Natick, MA 01760
877-937-9675

Michigan

Goodwill Industries of Greater Detroit
3111 Grand River Avenue
Detroit, MI 48208
888-232-4140

The ARC Michigan
1325 S. Washington Avenue
Lansing, MI 48910
800-292-7851

UCP Association of Metropolitan Detroit
23077 Greenfield Road, Suite 205
Southfield, MI 48075
800-827-4843

United Cerebral Palsy Assoc. of Michigan
3401 E. Saginaw, Suite 216
Lansing, MI 48912
517-203-1200
800-828-2714

Minnesota

Minnesota Department of Economic Security
2200 University Avenue, W, Suite 240
St. Paul, MN 55114
651-632-5108

Mississippi

Mississippi Department of Rehabilitation
P.O. Box 1698
Jackson, MS 39215
601-853-5315

Missouri

Missouri Division of Vocational Rehabilitation
3024 W. Truman Boulevard
Jefferson City, MO 65109
417-461-5467

Paraquad, Inc.
311 North Lindbergh
St. Louis, MO 63141
314-567-1558 x223

Montana

Montana State University
1500 North 30th
Billings, MT 59101
406-657-2312

Nebraska

Easter Seal Society of Nebraska
2727 West 2nd Street, Suite 471
Hastings, NE 68901
402-462-3031

Nevada

Southern Nevada Center for Independent Living
6039 Eldora, Ste. F-6
Las Vegas, NV 89146
702-889-4216

New Hampshire

Granite State Independent Living
21 Chenell Drive
P.O. Box 7268
Concord, NH 03302
800-826-3700

New Jersey

Epilepsy Foundation of New Jersey
429 River View Plaza
Trenton, NJ 08611
609-392-4900

United Cerebral Palsy Assoc. of New Jersey
354 South Broad Street
Trenton, NJ 08608
609-392-4004 x547

New Mexico

State Department of Education
435 St. Michael's Dr., Building D
Santa Fe, NM 87505
505-954-8523

New York

Abilities, Inc. for Disability Services
201 I.U. Willets Road
Albertson, NY 11507
516-465-1522

Barrier Free Living, Inc.
270 East Second Street
New York, NY 10009
212-677-6668 x123

Independent Living, Inc.
5 Washington Terrace
Newburgh, NY 12550
845-565-1162 x224

Neighborhood Legal Services, Inc.
295 Main Street, Room 495
Buffalo, NY 14203
716-847-0655 x262

Queens Independent Living Center
140-40 Queens Boulevard
Jamaica, NY 11435
718-658-2526

Research Foundation for Mental Hygiene
44 Holland Avenue, 6th Floor
Albany, NY 12229
518-485-2584

Resource Center for Independent Living
401-409 Columbia Street
P.O. Box 210
Utica, NY 13503
315-797-4642

North Carolina

Life Plan Trust, Inc.
P.O. Box 20545
Raleigh, NC 27619
919-782-4632

Department of Health & Human Services
2801 Mail Service Center
Raleigh, NC 27699
919-733-3364

TRI-County Industries, Inc.
1250 Atlantic Avenue
Rocky Mountain, NC 27801
252-937-3820

United Cerebral Palsy of North Carolina
620 N. West St., Suite 103
P.O. Box 27707
Raleigh, NC 27611
800-868-3787 x119

North Dakota

Rehab Services, Inc
1421 2nd Ave SW
Minot, ND 58701
701-839-4240

Northern Mariana Islands

Diverse Abilities
414 Kuwili Street, Suite 102
Honolulu, HI 96817
808-522-5400

Ohio

Center of Vocational Alternatives for Mental Health, Inc.
29 East Fifth Avenue
Columbus, OH 43201
614-294-7117

Legal Aid Society of Dayton
333 West First Street, Suite 500
Dayton, OH 45402
937-228-8088 x108

Legal Aid Society of Greater Cincinnati
215 East Ninth Street, Suite 200
Cincinnati, OH 45202
513-241-9400

Legal Services of Northwest Ohio
701 Spitzer Building
Toledo, OH 43604
419-255-0814

Linking Employment, Abilities & Potential
1468 W. 25th Street
Cleveland, OH 44113
216-696-2716

Oklahoma

University of Oklahoma College
106 Constitution, Building 158
Norman, OK 73072
405-325-4913

Oregon

Oregon Advocacy Center
620 SW Fifth Avenue, 5th Floor
Portland, OR 97204
503-243-2081

Pennsylvania

AHEDD
3300 Trindle Road
Camp Hill, PA 17011
717-763-0968

Goodwill Industries of Central Pennsylvania, Inc.
1150 Goodwill Drive
Harrisburg, PA 17105
610-777-7875

Pennsylvania Protection & Advocacy, Inc.
1414 N. Cameron Street, Suite C
Harrisburg, PA 17103
800-692-7443 x309

Puerto Rico

Caribbean Benefit Planning Project
P.O. Box 25277
San Juan, PR 00928
787-758-7901/ 0853

Rhode Island

Department of Human Services
600 New London Avenue
Cranston, RI 02920
401-222-2300 x421

South Carolina

South Carolina Vocational Rehabilitation Department
P.O. Box 15
West Columbia, SC 29171
803-896-6572

South Dakota

Black Hills Special Services Cooperative
221 South Central Ave.
Pierre, SD 57501
605-224-5336
800-224-5336

Tennessee

Center for Independent Living of Middle Tennessee
480 Craighead Street, Suite 200
Nashville, TN 37204
615-292-5803

Statewide Independent Living Council of Tennessee
480 Craighead Street, Suite 200
Nashville, TN 37204
615-297-2666

Texas

ARCIL, Inc.
825 E Rundberg
Austin, TX 78753
512-832-6349

Crockett Resource Center for Independent Living
1020 Loop 304 East
Crockett, TX 75835
936-544-2811

Houston Center for Independent Living
7000 Regency Square Boulevard,
Suite 160
Houston, TX 77036
713-974-4621

Imagine Enterprises
1402 Spring Cress Lane
Seabrook, TX 77586
281-474-7887

Odessa's Committee for Disabled, Inc.
208 W. 23rd
Odessa, TX 79761
915-580-3439

UCP of Tarrant County, Inc.
1555 Merrimac Circle
Suite 102
Fort Worth, TX 76107
817-332-7171 x603

Valley Association for Independent Living
105-C East Expressway 83
Pharr, TX 78577
956-781-7733

Volar Center for Independent Living
8929 Viscount
Suite 101
El Paso, TX 79925
915-591-0800

U.S. Virgin Islands

Caribbean Benefit Planning Project
P.O. Box 25277
San Juan, PR 00928
787-758-7901/ 0853

Utah

Utah State Office of Rehabilitation
250 East 500 South
Salt Lake City, UT 84111
801-887-9530

Vermont

Vermont Center for Independent Living
11 East State Street
Montpelier, VT 05602
802-229-0501

Virginia

Access Independence
403B South Loudoun St.
Winchester, VA 22601
540-662-4452

Blue Ridge Independent Living Center
1502-D Williamson Rd., NE
Roanoke, VA 24012
540-342-1231

Endeppence Center, Inc.
15 Interstate Corporate Ctr., Suite 100
Norfolk, VA 23502
757-461-8007

Junction Center for Independent Living, Inc.
247 W. Morgan Ave.
Pennington Gap, VA 24277
540-546-5093

Virginia Association of Community Rehabilitation Programs
6295 Edsall Road, Suite 175
Alexandria, VA 22312
703-461-8747

Washington

Employment Security Department
P.O. Box 9046
Olympia, WA 98507
360-438-3168

Positive Solutions
318 First Avenue South, Suite 300
Seattle, WA 98104
206-322-8181

West Virginia

West Virginia University
Center for Excellence in Disabilities
955 Hartman Run Rd
Morgantown, WV 26505
304-293-4692

Wisconsin

Employment Resources, Inc.
4126 Lien Road, Suite 104
Madison, WI 53704
1-877-826-1752

Independence First
600 W. Virginia Street, Suite 301
Milwaukee, WI 53204
414-291-7520

Riverfront Activity Center, Inc.
3000 South Avenue
La Crosse, WI 54601
608-784-9450

Wyoming

NOWCAP Social Security Assistance
851 Werner Court, Suite 102
Casper, WY 82601
866-523-1207 ■

Appendix E

Protection and Advocacy Organizations

The following organizations are available to help recipients of Social Security disability obtain information and advice about vocational rehabilitation and employment services and with advocacy or other related services needed to secure or regain gainful employment. Contact information is listed for every state, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands, American Samoa and the U.S. Virgin Islands.

Alabama

The University of Alabama
Box 870104
Tuscaloosa, AL 35487-0104
205-348-4928

Alaska

Disability Law Center of Alaska
3330 Arctic Blvd.
Suite 103
Anchorage, AK 99503
800-478-1234

American Samoa

American Samoa Protection and
Advocacy
P.O. Box 3937
Pago Pago, American Samoa 96799
011-684-633-2441

Arizona

Arizona Center for Disability Law
3839 N. Third Street, Suite 209
Phoenix, AZ 85012
602-274-6287

Arkansas

Disability Rights Center
1100 N. University Center
Little Rock, AR 72207
501-296-1775

California

Protection and Advocacy, Inc.
100 Howe Avenue
Suite 185N
Sacramento, CA 95825
916-488-9955

Colorado

Center for Legal Advocacy
455 Sherman Street, Suite 130
Denver, CO 80203
303-722-0300

Connecticut

Office of Protection and Advocacy for
Persons with Disabilities
60B Weston St
Hartford CT 06120
860-297-4342

District of Columbia

University Legal Services
300 I Street, NE, Ste 202
Washington, D.C. 20002
202-547-4747

Delaware

Community Legal Aid Society, Inc.
Community Services Bldg.
100 W. 10th Street, Ste 801
Wilmington, DE 19801
302-575-0660 X220

Florida

Advocacy Center for Persons with
Disabilities, Inc.
2671 Executive Center Circle, W 100
Tallahassee, FL 32301
813-233-2920

Georgia

Georgia Advocacy Office
100 Crescent Centre Parkway, Suite 520
Tucker, GA 30084
404-885-1234

Guam

Guam Legal Services Corporation
113 Bradley Place
Hagatna, Guam 96910
671-477-9811

Hawaii

Hawaii Disability Rights Center
900 Fort St., Suite 1040
Honolulu, HI 96813
808-949-2922

Idaho

Comprehensive Advocacy, Inc.
4477 Emerald Street, Suite B-100
Boise, ID 83706
208-336-5353

Illinois

Equip for Equality, Inc.
11 East Adams
Suite 1200
Chicago, IL 60603
312-341-0022

Indiana

Indiana Protection & Advocacy Services
4701 N. Keystone Ave
Suite 222
Indianapolis, IN 46205
317-722-5555

Iowa

Iowa Protection and Advocacy
3015 Merle Hay Road, Suite 6
Des Moines, IA 50310-1270
800-779-2502

Kansas

Kansas Advocacy & Protective
Services, Inc.
3745 SW Wanamaker
Topeka, KS 66610
785-273-9661

Kentucky

Department of Public Advocacy
Protection & Advocacy Division
100 Fair Oaks Lane, Third Floor
Frankfort KY 40601
502-564-2967

Louisiana

Advocacy Center
225 Baronne St., Ste. 2112
New Orleans, LA 70112
800-960-7705 X481

Maine

Disability Rights Center of Maine
24 Stone St.
Kennebec, ME 04338
207-626-2774

Maryland

Maryland Disability Law Center
1800 N. Charles St., Suite 202
Baltimore, MD 21201
410-727-6352

Massachusetts

Disability Law Center, Inc.
11 Beacon St., #925
Boston, MA 02108
800-872-9992

Michigan

Michigan Protection and Advocacy
Service, Inc.
106 W. Allegan, Suite 300
Lansing, MI 48933-1706
517-487-1755

Minnesota

Legal Aid Society of Minneapolis
430 First Avenue
North Suite 300
Minneapolis, MN 55401
612-332-1441

Mississippi

Mississippi Protection & Advocacy
System, Inc.
5305 Executive Place, Suite A
Jackson, MS 30206
601-981-8207

Missouri

Missouri Protection & Advocacy
Services
925 South Country Club Drive
Jefferson City, MO 65109
573-893-3333

Montana

Montana Advocacy Program
400 North Park, 2nd Floor
P.O. Box 1681
Helena, MT 59624
406-449-2344

Native American

DNA-People's Legal Services, Inc
PO Box 306
Window Rock, AZ 86515
505-368-3216

Nebraska

Nebraska Advocacy Services, Inc.
215 Centennial Mall South, Suite 522
Lincoln, NE 68508
402-474-3183

Nevada

Nevada Disability Advocacy Center
6039 Eldora Avenue
Suite C - Box 3
Las Vegas, NV 89146
775-333-7878

New Hampshire

Disabilities Rights Center, Inc.
P.O. Box 3660
Concord, NH 03302
603-228-0432

New Jersey

New Jersey Protection & Advocacy, Inc.
210 South Broad St., 3rd Floor
Trenton, NJ 08608
609-292-9742

New Mexico

Protection & Advocacy System
1720 Louisiana, NE, Suite 204
Albuquerque, NM 87110
505-256-3100

New York

State Commission on Quality of Care
for the Mentally Disabled
401 State St.
Schenectady, NY 12305-2397
518-381-7001

North Carolina

Governor's Advocacy Council for
Persons with Disabilities
1314 Mail Service Center
Raleigh, NC 27699-1314
919-733-9250

North Dakota

Protection and Advocacy Project
400 East Broadway
Suite 616
Bismarck, ND 58501-4073
701-328-2950

Northern Mariana Islands

Northern Mariana Protection &
Advocacy Systems, Inc.
P.O. Box 503529
Saipan, MP 96050
670-235-7274

Ohio

Ohio Legal Rights Service
8 East Long
Suite 500
Columbus, OH 43215-2999
614-466-7264

Oklahoma

Oklahoma Disability Law Center, Inc.
2915 Classen Blvd.
Suite 300
Oklahoma City, OK 73106
405-525-7755

Oregon

Oregon Advocacy Center
620 SW Fifth Avenue, Suite 500
Portland, OR 97204-1428
503-243-2081

Pennsylvania

Pennsylvania Protection & Advocacy,
Inc.
1414 N. Cameron St.
Harrisburg, PA 17105
215-238-8070

Puerto Rico

Office of the Ombudsman for Persons
with Disabilities
Caribbean Office Plaza #670
Miramar P.O. Box 41309
San Juan, PR 00940
787-724-0670

Rhode Island

Rhode Island Disability Law Center,
Inc.
349 Eddy St.
Providence, RI 02903
401-831-3150

South Carolina

Protection & Advocacy for People with
Disabilities, Inc.
3710 Landmark Dr., Suite 208
Columbia, SC 29204
803-782-0639

South Dakota

South Dakota Advocacy Services
221 South Central Avenue
Pierre, SD 57501
605-224-8294

Tennessee

Tennessee Protection and
Advocacy, Inc.
2416 21st Avenue South
Nashville, TN 37212
615-298-1080 X18

Texas

Advocacy, Inc.
7800 Shoal Creek Blvd, Suite 171-E
Austin, TX 78757
713-974-7691

Utah

Disability Law Center
455 East 400 South, Suite 410
Salt Lake City, UT 84111
801-363-1347

Vermont

Vermont Protection & Advocacy
141 Main St, #7
Montpelier, VT 05602
802-229-1355 X101

Virginia

Department for Rights of Virginians
with Disabilities
202 N. Ninth St., 9th Floor
Richmond, VA 23219
804-225-2042

Virgin Islands

Virgin Islands Advocacy, Inc.
63 Estate Carlton
Frederiksted, St.Croix U.S. VI 00840
340-772-1200
340-772-4641 (TDD)

Washington

Washington Protection & Advocacy
System
180 W Dayton, Suite 102
Edmonds, WA 98020
425-776-1199
800-562-2702 (toll free)
(425) 776-1648 TTY
800-905-0209 (toll-free TTY)

West Virginia

West Virginia Advocates, Inc.
Litton Bldg., 4th Floor
1207 Quarrier Street
Charleston, WV 25301-1842
304-346-0847
800-950-5250 (V/TDD)

Wisconsin

Wisconsin Coalition for Advocacy
16 North Carroll St., Suite 400
Madison, WI 53703
414-342-8700

Wyoming

Protection & Advocacy System, Inc.
320 West 25 Street, 2nd FL
Cheyenne, WY 82001
307-632-3496 ■

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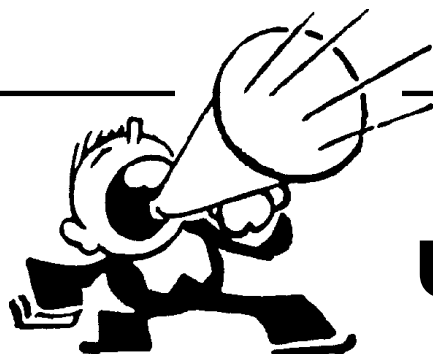
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David A. Morton has degrees in psychology (B.A.) and medicine (M.D.). For 14 years he was a consultant for disability determination to the Social Security Administration in Arkansas. He was Chief Medical Consultant for eight years of that time. In that capacity, he hired, trained, supervised and evaluated the work of medical doctors and clinical psychologists in determining mental disability claims. He also supervised medical disability determinations of physical disorders and personally made determinations of both physical and mental disorders in adults and children in every specialty of disability medicine. Since 1983, Dr. Morton has authored several books on Social Security disability used by attorneys and federal judges.